G52001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G52001 Registered No. P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Bella- Balto. County-
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Selfridge Rd Victory Villa (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alton W. Corkran

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-6490

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1910

8. AGE: Years	Months	Days	If less than one day
36	5 6	17 6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business Sun Cab Company

FATHER
12. Name Alton Thomas Corkran
13. Birthplace Eastern Shore, Maryland

MOTHER
14. Maiden Name Hattie Medinger
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Ellen Corkran
(b) Address 3 Selfridge Rd., Victory Villa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 28 1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1947, at 10 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Impossible to give due to advanced putrefactive changes.

Due to

Other Conditions No wounds.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 5/22/47

VS 151

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03669

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.
How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4229 Park Heights Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ALEX ADLER

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Adler
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 5-6-1893

8. AGE: Years	Months	Days	If less than one day
54	0	2	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and atate)
10. Usual occupation: Plumber
11. Industry or business
FATHER 12. Name: Jacob Adler
13. Birthplace: Russia
MOTHER 14. Maiden name: Lee Adler
15. Birthplace: Russia
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-9-47 (month) (day) (year)
Cemetery or crematory: Rosedale
Location: Phil Rd. & Hamilton Ave
18. Funeral director: Jack Lewis Inc.
Address: 1439 E. Balto
19. 5-9-47 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1947 19... at 3:40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19, 1947 to May 8, 1947 and that I last saw him alive on May 8, 1947

Immediate cause of death	DURATION
HEART DISEASE; HYPERTENSION AND CORONARY ARTERIOSCLEROSIS;	5 yrs.
CARDIAC ENLARGEMENT; MYOCARDIAL INSUFFICIENCY; ANGINAL SYNDROME	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of Injury: ... Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, CLIN. DIRECTOR
M. D. or other
Address: V.AH. Fort Howard, Md. Date signed 5-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 0304 K

1. PLACE OF DEATH:
County Baltimore
City or town Baltimore, Maryland (Essex)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Baltimore, Maryland (Essex)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 Terrace Road
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME MATTHEW ALBRECHT

3. (b) Social Security Number 209 -09-8298

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Elva M. Albrecht
6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) August 15, 1890

8. AGE: Years	Months	Days	If less than one day
56	8	25	...hrs. ...min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Pattern Maker
11. Industry or business Martin Co.
FATHER 12. Name Carl Albrecht
13. Birthplace Germany
MOTHER 14. Maiden name ?
15. Birthplace ?
16. Informant Mrs. Elva M. Albrecht
Address 1 Terrace Rd., Essex, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/12/47 (month) (day) (year)
Cemetery or crematory OAK LAWN CEMETERY
Location BALTIMORE, MARYLAND
18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY
19. 5-12-47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 5.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1943, to May 10 1947
and that I last saw h... alive on May 9 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Conrad L. Pettry MD M. D. or other
Address 1706 N Wash. St Date signed 5/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03671

Reg. Dist. No.

1. PLACE OF DEATH:
County: Balto.
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
Texas Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Texas Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: Texas Rd -

3.(a) FULL NAME: Cecelia Elizabetta Anderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married -

6.(b) Name of husband or wife: Frank E. Anderson
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): Dec 24, 1863

8. AGE:

Years	Months	Days	If less than one day
83	4	22	hrs. min.

9. Birthplace: Hampden Balto. Co. Md -
(Town, county, and state)
10. Usual occupation: Housewife -
11. Industry or business: Home
FATHER 12. Name: John C. Armstrong
13. Birthplace: Md -
MOTHER 14. Maiden name: Nancy - Black -
15. Birthplace: Md -
16. Informant: Frank E. Anderson
Address: Texas Md -
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/47 (month) (day) (year)
Cemetery or crematory: St Josephs Cemetery -
Location: Texas Md
18. Funeral director: John Burns Sons
Address: Towson, Md.
19. May 16 1947 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1947, at 11 45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 15 1946, to May 15 1947
and that I last saw her alive on 5/14 1947

Immediate cause of death: Chronic Nephritis - (Uraemic Coma) — DURATION: 5 yrs -
Due to: Arterio sclerosis -
Due to: Senility -
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other
Address: Cockeysville Md. Date signed 5/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03672

Reg. Dist. No. 42

1. PLACE OF DEATH:
County BALTIMORE
City or town RURAL - BALTIMORE, 27.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 YEARS
Hospital, institution, or street address where death occurred:
2003 HALETHORPE AVE.
How long in hospital or institution? HOME.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County BALTIMORE.
City or town RURAL - BALTIMORE, 27.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2003 HALETHORPE AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CHARLES W. ASKINS

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED.

6.(b) Name of husband or wife MARGARET ANNE ASKINS
6.(c) If alive, give age (DEAD) years

7. Birth date of deceased (mo., day, yr.) FEB. 18, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	26	hrs. min.

9. Birthplace FREDERICSBURG, VIRGINIA (Town, county, and state)
10. Usual occupation BOILER MAKER
11. Industry or business STEEL
FATHER 12. Name LEMUEL ASKINS
13. Birthplace NEW HAVEN, CONN
MOTHER 14. Maiden name MARGARET HINES
15. Birthplace BALTIMORE, MD.
16. Informant ROBERT B. ASKINS
Address 1707 SUMMIT AVE.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20th 47 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cem.
Location 2930 Frederick Ave
18. Funeral director John J. Cowan & Son
Address 901-03 N. Hollins St.
19. 5-19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 MAY 1947, at 9:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1947, to MAY 1947
and that I last saw h alive on 3 MAY 1947

Immediate cause of death	DURATION
CORONARY OCCLUSION	1 HOUR
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Goodman M.D.
M. D. or other
Address 1334 SULPHUR SPRING RD. Date signed 16 MAY 47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03673

P

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 2616 Liberty Parkway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2616 Liberty Pky.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Jessie M. Atkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Norman M. Atkins Sr.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 21st 1895

8. AGE: Years	Months	Days	If less than one day
52	0	12	..... hrs. ..... min.

9. Birthplace: Richmond Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Jeremiah M. Tiller
13. Birthplace: Va.

MOTHER
14. Maiden name: Emma Davis
15. Birthplace: Va.

16. Informant: Norman M. Atkins Sr.
Address: 2616 Liberty Parkway Dundalk
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/6/47 (month) (day) (year)
Cemetery or ~~crematory~~: Oak Lawn
Location: Eastern Ave. Extended
18. Funeral director: William Cook Inc
Address: 1217 E. Paul St
19. 5/5 19 47 (Date rec'd by registrar) D.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 19 47, at 8:45 a.m. p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Coronary Occlusion	10 Min
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. Bevans M.D.
Major Med. Corps M.C.
Address: Dundalk Md. Date signed 5/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

03674

Reg. Diat. No. 30

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years, 6 months, 5 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 19 years, 6 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: -
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Martha Berry

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	15	hrs. min.

9. Birthplace: Prince George County, Md.
(Town, county, and state)

10. Usual occupation: odd jobs
11. Industry or business: hotels

FATHER
12. Name: Zacharah Berry
13. Birthplace: ?

MOTHER
14. Maiden name: Elizabeth Addison
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 27 1947 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: Washington D.C.

18. Funeral director: Jos. Gawlus Sons
Address: 1706 Penna. ave. N.W. Washington D.C.

19. 5-26- 1947 (Date rec'd by registrar) Henry L. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 47 at 1:00 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 19 27, to May 22 19 47
and that I last saw her alive on May 22 19 47

Immediate cause of death	DURATION
Right lower broncho-pneumonia	24 hours
Due to: Chronic valvular heart disease	Indef.
Due to: Chronic myocardial arterio - sclerotic cardiovascular renal	Indef.
Other conditions: disease.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk M. D. or other
Address: Catonsville 28, Md. Date signed: 5/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03675

Reg. Diat. No. G

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since May 30, 1946

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since May 30, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State Maryland County Baltimore

City or town Gardenville-Baltimore 27 (If outside city or town limits, write RURAL and give nearest town)

Street No. 7938 Charlestown Ave (If rural, give LOCATION)

2.(a) If veteran, name war ... 215-05-9679

3.(a) FULL NAME Edith Bigley

3.(b) Social Security Number 215-05-9679

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward W. Bigley

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): February 20, 1919

8. AGE: Years 28 | Months 2 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Charles Frost

FATHER 13. Birthplace: Baltimore md

MOTHER 14. Maiden name: Lotty Green

MOTHER 15. Birthplace: Baltimore Md

16. Informant: Personal History- Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. (Burial, ~~cremation, or removal~~. Which?) Burial Date thereof 5/5/47 (month) (day) (year)

Cemetery or ~~crematory~~: Mt Cathedral

Location: Baltimore Md

18. Funeral director: Wilhelm Cook Co

Address: 1217 St Paul St

19. 5/3 1947 (Date rec'd by registrar) A.W. Fedrick Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1947, at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1946 to May 1 1947 and that I last saw h[illegible] alive on May 1 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	July 1st 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W E Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 5-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 03676

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 91 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 91 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 755 W. Saratoga Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: THOMAS A. BLAIR

3. (b) Social Security Number: 217-26-4213

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-22-1915

8. AGE: Years	Months	Days	If less than one day
31	8	14	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: Cornelius
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Catherine Reeder
15. Birthplace: Maryland
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10, 1947 (month) (day) (year)
Cemetery or crematory: Baltimore National Cem.
Location: Baltimore, Md.
18. Funeral director: Mrs. George A. Hollan
Address: 1601 Druid Hill Ave.
19. 5-9-47 (Date rec'd by registrar) C.W. Aldrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1947 at 8:26a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4, 1947 to May 6, 1947 and that I last saw him alive on May 6, 1947

Immediate cause of death	DURATION
CARCINOMA OF SIGMOID COLON WITH GENERALIZED METASTASIS TO SPINE, LUNGS AND LIVER	9 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, M.D., CLIN. DIR.
M. D. or other
Address: V.A.H. Fort Howard, Md. Date signed: 5-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 03677 44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Stemmers Run
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Stemmers Run
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8343 Pulaski Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: JOHN H. BOHLEN, Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Minnie W. Bohlen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28th, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	20	hrs. min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: Truck Farmer

11. Industry or business

FATHER
12. Name: John Bohlen
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden name: Mary E. Mohr
15. Birthplace: Baltimore County, Md.

16. Informant: Mr. Clarence E. Bohlen
Address: 8343 Pulaski Highway

17. burial (Burial, cremation, or removal. Which?) Date thereof: May 21st/47 (month) (day) (year)

Cemetery or crematory: Zion Lutheran

Location: Stemmers Run

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. May 19 1947 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH: May 18th 1947, at 8:50 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 17 1947, to May 18 1947 and that I last saw him alive on May 18 1947

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden

Due to: Arteriosclerotic Cardio Vascular disease — DURATION: 2 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo M. Baumgardner M. D. or other

Address: Balto 6 Md. Date signed: 5-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

C3678 84

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore Bof 236 A
City or town Baltimore 21 - Rt 13 Cape May Rd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
Bof 236A - Cape May Rd Rt 13 - Balto 20
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 McHenry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James William Braud (Braud)

3.(b) Social Security Number 217-03-5693

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife Anna Margaret Braud. deceased. 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	8	13		

9. Birthplace New Orleans, La. (Town, county, and state)
10. Usual occupation Structural Iron worker
11. Industry or business Building

FATHER
12. Name Thomas Braud.
13. Birthplace New Orleans, La.

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs. Clarence Jenkins
Address Bof 236A. Rt 13 Balto 21, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22. 1947 (month) (day) (year)
Cemetery or crematory London Park
Location 3801 Frederick Ave.
18. Funeral director Mr. Mrs. John W. Teufel & Son
Address 5311 Edmondson Ave.

19. 5-20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 8:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947, to May 1947
and that I last saw h.i.m. alive on 19 May 1947

Immediate cause of death	DURATION
— Pulmonary edema - cancer	undetermined
anoxia	
Due to advanced pulmonary Tuberculosis	
Due to	
Other conditions severe cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Evan D. Cook, M.D.
Address 901 Fruchey Ave Balto 20, md. M.D. or other Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48a

03679

CERTIFICATE OF DEATH

Reg. Dist. No. 44

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Riverside Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Beulah Maig Brandt.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or ~~wife~~ Charles C. Brandt

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 21 - 1890

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER 12. Name David Neal

13. Birthplace Balto.

MOTHER 14. Maiden name Sarah Taskes

15. Birthplace Balto,

16. Informant Mrs. Chas. E. Brandt

Address 200 Riverside Dr.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-27-47 (month) (day) (year)

Cemetery or crematory Bachmans Cem

Location Balto, Md.

18. Funeral director John S. Connelly

Address 418 Eastern Blvd

19. 5-27-47 19 John S. Connelly Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to May 24 1947

and that I last saw her alive on May 24 1947

	DURATION
Immediate cause of death Toxemia	6 mos
Due to Carcinoma of Cervix	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. M. Baumgardner M. D. or other

Address Balto 6 Md Date signed 5-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d

C3680

Reg. Dist. No. 40

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Hereford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Hereford
(If outside city or town limits, write RURAL and give nearest town)
Street No. Monkton Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lionel B. Brenize

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife May Brenize
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 7 - 1878

8. AGE: Years 69 | Months 2 | Days 27 | If less than one day hrs. min.

9. Birthplace Shrewsbury Pennsylvania
(Town, county, and state)
10. Usual occupation Telegraph Operator
11. Industry or business Retired 2 years

FATHER
12. Name Joseph Brenize
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Jennie Hannah Bailey
15. Birthplace Maryland

16. Informant Mrs. May Brenize
Address Monkton Road, Hereford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7-1947 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18. Funeral director Burgee Funeral Home
Address 3631 Falls Road, Baltimore

19. 5/6 1947 Edw. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4- 1947, at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947, to May 4 1947
and that I last saw h-- alive on May 4 1947

Immediate cause of death	DURATION
Carcinoma Rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. M. France M. D. or other
Address Parkton, Md. Date signed 5/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93 d

03681

CERTIFICATE OF DEATH

Reg. Diat. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Upper Falls P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Upper Falls P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bradshaw & Raphel Roads
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MARY E. BUCKINGHAM

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Harvey S. Buckingham

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19th, 1880

8. AGE: Years	Months	Days	If less than one day
66	6	11	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Mahlom Gregg

13. Birthplace

MOTHER 14. Maiden name: McCubbin

15. Birthplace

16. Informant: Mr. Arthur Buckingham

Address: Bradshaw Road

17. burial (Burial, cremation, or removal. Which?) Date thereof: June 3rd/47 (month) (day) (year)

Cemetery or crematory: St. Johns Episcopal

Location: Kingsville, Md.

18. Funeral director: Lasacks Funeral Home

Address: 7401 Belair Road

19. 6/2 (Date rec'd by registrar) 19 47 W M Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31st 19 47 at 11:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 19 46, to May 31, 19 47 and that I last saw h[illegible] alive on May 31, 19 47

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hypertension	7 yrs
Due to: Cardiovascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clifford T. Hudson M.D. M. D. or other

Address: [illegible] York Rd Date signed 6/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

C3682

Reg. Diat. No. 32

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore Co.

City or town: Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two weeks

Hospital, institution, or street address where death occurred: Catonsville Convalescent Home

How long in hospital or institution? Two weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 Compass Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Charles M. Burke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian M. Ayers Burke

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 10. 1891

8. AGE: Years	Months	Days	If less than one day
55	7	19	hrs. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: Mechanic at

11. Industry or business: Glen L. Martins

FATHER 12. Name: James E. Burke

13. Birthplace: Baltimore Md

MOTHER 14. Maiden name: Julia F. Burke Bayley

15. Birthplace: Baltimore Md

16. Informant: Mrs Geis (Sister)

Address: 731 Old Harford Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31, 1947 (month) (day) (year)

Cemetery or crematory: London Park Cemetery

Location: 3801 Frederick Rd P.O.

18. Funeral director: Edmund M. Goldsborough

Address: 924 E. Eager St Balto 2 Md.

19. May 29 1947 A. W. Hedrick Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 29 1947 to May 29 1947 and that I last saw h... alive on May 29 1947

Immediate cause of death	DURATION
a. Coronary occlusion	Instn.
Due to	
Due to	
Other conditions: Ruptured Tympanic	Feb 1947

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edmund M. Goldsborough, M. D. or other

Address: Catonsville Md Date signed: 5/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46b

03683

CERTIFICATE OF DEATH

Reg. Diat. No. 4X

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County:

City or town: Miami (If outside city or town limits, write RURAL and give nearest town)

Street No. 1759 5th Court (If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

MILES CARTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Camie Carter

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): 2-15-1890

8. AGE: Years	Months	Days	If less than one day
57	3	1	....hrs. ....min.

9. Birthplace: Mississippi (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER — 12. Name: Peter Carter

13. Birthplace: Scooba, Miss

MOTHER — 14. Maiden name: Eliza Giles

15. Birthplace: Miss.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-24-47 (month) (day) (year)

Cemetery or crematory: Blue Chapter Cem

Location: Scooba, Mississippi

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St.

19. 5-19-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 19 47 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 19 47 to May 16 19 47 and that I last saw him alive on May 16 19 47

Immediate cause of death	DURATION
Carcinoma of Stomach with metastases	19 Days Plus.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. J. Cavalieri
R. J. CAVALIERI, M. D. M. D. or other

Address: V.A. FORT HOWARD, MD. Date signed: 5-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly and correctly age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.15M

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

03684

8

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 10 months, 4 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 5 years, 10 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 6014 Pinehurst Road (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Elizabeth Casserly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas Casserly

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 2, 1866

8. AGE: Years	Months	Days	If less than one day
80	8	28	hrs. min.

9. Birthplace Govans, Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business Home

FATHER 12. Name Thomas Feeley

13. Birthplace Ireland

MOTHER 14. Maiden name Catherine Dougherty

15. Birthplace Ireland

16. Informant Hospital records

Address Catonsville-28, Maryland

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6-3-47 (month) (day) (year)

Cemetery or crematory CATHEDRAL

Location CITY

18. Funeral director WIEDEFELD & SON

Address GREENMOUNT AVE & 22ND

19. 6/2 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1941 to May 30 1947

and that I last saw her alive on 19

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Chronic cardiovascular renal	
Due to disease	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 5-30-47

ca. 273

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03685

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 288 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 288 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: 506 W. Mulberry Street Balto., Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: See above.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ROCCO CENTANNI

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-5-1890

8. AGE:

Years	Months	Days	If less than one day
57	2	22	..... hrs. ..... min.

9. Birthplace: France (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: Carmine Centanni

FATHER — 13. Birthplace: Switzerland

MOTHER — 14. Maiden name: Frances

MOTHER — 15. Birthplace: Switzerland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28-1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Ellsworth Armacost

Address: 3911 Liberty Hgts. Ave., Balto., Md.

19. May 29 19 47 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1947, at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12, 1946 to May 27, 1947 and that I last saw him alive on May 27, 1947

Immediate cause of death	Aortic Insufficiency	11 Yrs.
Due to	Syphilis	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison

R. M. CULLISON, M.D. CLIN. M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 5-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

03686 P

CERTIFICATE OF DEATH

Reg. Diat. No. 4X

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 225 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 225 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 628 Smitston St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: WILBERT CLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married-Common-Law-Wife

6.(b) Name of husband or wife: Common-Law-Wife- Mrs. Mary Gray (Clark) 6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.): 3-11-1892

8. AGE: Years	Months	Days	If less than one day
55	2	4	...hrs. ...min.

9. Birthplace: Laurel, Md. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: Wilbert Clark
13. Birthplace: Laurel, Md.

MOTHER — 14. Maiden name: Liza Clark
15. Birthplace: Laurel, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Maryland

18. Funeral director: Mrs Katie R. Williams
Address: 322 N Schroeder St

19. 5/20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1947, at 8:25 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 2, 1946 to May 15, 1947 and that I last saw him alive on May 15, 1947

Immediate cause of death	DURATION
PULMONARY HEMORRHAGE	One Hr.
Due to: Pulmonary Tuberculosis	2 yrs. plus
Due to:	
Other conditions: Diabetes Mellitus	2 yrs.
Addisons Disease	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: L. Boyd Jr. M.D. (OD)
M. D. or other

Address: V.A.H. Fort Howard, Md. Date signed: 5-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

03687

CERTIFICATE OF DEATH

Reg. Diat. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs.

Hospital, institution, or street address where death occurred: Megans Road

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Megans Rd. Near Offutt Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Laura Margaret Clingman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife George L. Clingman

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) May 30, 1869

8. AGE:

Years	Months	Days	If less than one day
77	11	6	...hrs. ...min.

9. Birthplace Baltimore Maryland

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business —

FATHER

12. Name John Deelker

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden name Elizabeth Schlag

15. Birthplace Baltimore Md.

16. Informant George L. Clingman

Address Randallstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 47 (month) (day) (year)

Cemetery or crematory M. E. Christ

Location Randallstown, Md.

18. Funeral director Frank H. Yewell

Address Pikesville, Maryland

19. 5/6/1947 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 11:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19... to May 5, 1947 and that I last saw h... alive on May 5, 1947

Immediate cause of death	DURATION
Chr Vat Ht Dis and	
Due to Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 5/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

C3688 38

Reg. Dist. No.

P

M

1. PLACE OF DEATH:

County Baltimore

City or town Towsontown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 617 Dunkirk Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Towsontown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Dunkirk Road

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Thomas E. Conn

3. (b) Social Security Number 225-12-7480

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lillie May

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12 1872

8. AGE: Years	Months	Days	If less than one day
74	9	28	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business

FATHER 12. Name Daniel A. Conn

13. Birthplace Kensington Md

MOTHER 14. Maiden name Mary Todd

15. Birthplace Guilford Md

16. Informant Edward Conn

Address 617 Dunkirk Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/47 (month) (day) (year)

Cemetery or crematory Loudoun

Location Mt. Lawn Md

18. Funeral director Gilbert & Son

Address 1317 E. Pont St

19. 5-12-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to May 10 1947

and that I last saw h... alive on May 9, 1947

Immediate cause of death Coronary Thrombosis

DURATION 8 hrs

Due to Arteriosclerosis 9 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. B. Eudor M. D. or other

Address 7201 York Rd Date signed 5-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03690

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Relay 27, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
Relay Sanitarium

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: High Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
Miss Elsie M. Crew

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

Cousin:
6.(b) Name of husband or wife: J. Lewin Burris

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1889

8. AGE: Years	Months	Days	If less than one day
57	5	4	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Practical nurse

11. Industry or business

FATHER
12. Name: Samuel Crew
13. Birthplace: Worton, Md.

MOTHER
14. Maiden name: Clara Smith
15. Birthplace: unknown

16. Informant: Cousin J. Lewin Burris
Address: P.O. Drawer 359- Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12, 1947 (month) (day) (year)

Cemetery or crematory: Spring Hill Cem.

Location: Easton Talbout Co. Maryland

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. May 9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 47, at 7:A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1-47 19..., to 5-9-47 19...

and that I last saw her alive on 5-8-47 19...

	DURATION
Immediate cause of death:	
Congestive heart failure	7 wks.
Due to:	
Arteriosclerotic heart disease	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis P. Tuttle M.D.
M.D. or other

Address: Relay, 27 Md. Date signed: 5/9/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

03691 30
Reg. Dist. No.

P

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Ingleside Ave. & Johnnycake Rd.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ingleside Ave. & Johnnycake Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Hilton Cutcher, Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma A. Cutcher (nee Masurock)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	12	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Tavern Proprietor
11. Industry or business Own Business

FATHER
12. Name Harry Cutcher
13. Birthplace Md.

MOTHER
14. Maiden name Laura Hilton
15. Birthplace Md.

16. Informant Mrs. Emma A. Cutcher
Address Ingleside Ave. & Johnny cake Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10/47 (month) (day) (year)
Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.
18. Funeral director Harry F. Nuttle
Address 4101 Edmondson Ave.

19. 5-9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7/47. 19..... at 4:15 P. M.

I CERTIFY that death occurred on the date above stated: that I attended deceased from March 3 1947 to May 7 1947 and that I last saw h...m...alive on May 5 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour
Due to Myocarditis	?
Due to Cardiac Decompensation	2 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George E. Utton M. D. or other
Address 603 33rd Ave. Catonsville 28 Md. Date signed 5-7-47

G52205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52205 P

Registered No.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 EDMONDSON AVE
(c) Hospital or institution:
NELLIE HOOD HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 S. ELLWOOD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CYRUS H. DANIELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 2 1871

8. AGE:

Years	Months	Days	If less than one day
75	10	28	hr. min.

9. Birthplace W. VA
(Town, county, and state)

10. Usual Occupation RETIRED C. ENGINEER

11. Industry or business

FATHER
12. Name ELI DANIELS
13. Birthplace PA

MOTHER
14. Maiden Name SARAH WAYT
15. Birthplace W. VA

16 (a) Informant CLARA B. WHEATLEY
(b) Address 624 S. ELLWOOD AVE

17 (a) BURIAL (b) Date thereof JUNE 1 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory JUNIOR O.U.A.M
Location ORIOLE MD

18 (a) Funeral director AMBROSE INC
(b) Address 414 N. FRANKLINTOWN RD

19 MAY 31 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947, to May 30 1947, and that I last saw h[illegible] alive on May 30 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cerebral Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address Date signed 5/31/47 M. D.

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 03693 P

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Md. Arnoldie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 720 Cunneslie Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dr L Wilson Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of ~~husband~~ or wife: Alma J. Davis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 18 1862

8. AGE: Years: 84 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Frederick Co Md
(Town, county, and state)

10. Usual occupation: ~~Dentition~~

11. Industry or business: Dentist

FATHER
12. Name: L H Davis
13. Birthplace: Frederick Co Md

MOTHER
14. Maiden name: Miles
15. Birthplace: Montgomery Co Md

16. Informant: Alma J Davis
Address: 720 Cunneslie Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 1947 (month) (day) (year)
Cemetery or crematory: Manocacy Cem
Location: Beallesville Md

18. Funeral director: John C Mosan
Address: 3000 E Baltimore St

19. 5-21 19 47 (Date rec'd by registrar) Authorized Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 19 47, at 11 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/20 19 47, to 5/18 19 47
and that I last saw h... alive on 5/17 19 47

Immediate cause of death	DURATION
Heart Failure	2 weeks
Due to: Myocardeal Degeneration	2 yrs
Due to: arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles F O'Donnell M.D.
M. D. or other
Address: 730 Aisquith St Date signed: 5/18/47
Towson

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 13644

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address, where death occurred: Maiden Rt. #3 B&O.R.R. Tracks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ~~712 Dundalk Ave.~~ 2465 Fairway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Louie J. DeSisco

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 28, 1942

8. AGE: Years	Months	Days	If less than one day
4	6	3	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Nicholas J. DeSisco
13. Birthplace: Italy
MOTHER 14. Maiden name: Millie
15. Birthplace: Pennsylvania
18. Informant: Nicholas J. DeSisco
Address: 2465 Fairway, Dundalk
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5, 1947 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Germany Hill Road
18. Funeral director: Roland L. Fisher
Address: 712 Dundalk Ave.
19. 5/3/47 (Date rec'd by registrar) 19.. M. Barrume Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 47, at 3:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 1 1947
and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Drowning (accidental)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5/1/47
Where did injury occur? Dundalk (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Drowning Injured at work? no

23. SIGNATURE: M. Barrume M.D.
Deputy Medical Examiner
Address: Dundalk, Md. Date signed: 5/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

87d 03695

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 9 months, 19 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 8 years, 8 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 325 East Lanvalle Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Chester Dettinger

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Viola Dettinger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4, 1905

8. AGE: Years	Months	Days	If less than one day
41	11	15	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: Elmer Dettinger

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Elizabeth Gohn

15. Birthplace: Pennsylvania

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial, cremation, or removal. Which? Burial Date thereof 5/19/47 (month) (day) (year)

Cemetery or crematory: St Lukes

Location: Old Lyon Pa

18. Funeral director: Wilhom & Col Dyer

Address: 2170 Cool St

19. 5/19 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 19 47 at 12:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 19 38 to May 19 19 47

and that I last saw h... im alive on May 19 19 47

Immediate cause of death	DURATION
Multiple Sclerosis	indefinite
Due to Chronic myocarditis	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

.03698 P

13 1a

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 6 months, 23 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 4 years, 6 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2732 North Calvert Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

John Oliver DeVries

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: Emma Kohler DeVries

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): February 2, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	5	hrs. min.

9. Birthplace: Maryland (Marriottsville)
(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: W.P.A.

FATHER
12. Name: John Ollig DeVries
13. Birthplace: Maryland (Marriottsville)

MOTHER
14. Maiden name: Emily Wadlow
15. Birthplace: Maryland (Freedom)

16. Informant: Hospital records
Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/9/47 (month) (day) (year)
Cemetery or crematory: Freedom Cem.
Location: Carroll Co., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.

19. 5 8 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 19 47, at 1:30 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 42, to May 7 19 47 and that I last saw h im alive on May 7 19 47

Immediate cause of death	DURATION
Coronary accident	indefinite
Due to: Chronic arteriosclerotic cardiovascular-renal disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

Isadore Tuerk

C. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836

03697 Reg. Dist. No. 44

P

1. PLACE OF DEATH:
County: Balto
City or town: Colgate (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years.
Hospital, Institution, or street address where death occurred: 404 Lowery Ave., Colgate
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Colgate (If outside city or town limits, write RURAL and give nearest town)
Street No. 404 Lowery ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frederick C. Dietrich

3.(b) Social Security Number: 218-05-9052

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widowed

6.(b) Name of husband or wife: Margaret Dietrich
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1874

8. AGE: Years 72 | Months 1 | Days | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: General Work
11. Industry or business: Cemeteries
FATHER 12. Name: Dont Know
13. Birthplace: Md
MOTHER 14. Maiden name: Dont Know
15. Birthplace: Md
16. Informant: Irving Dietrich
Address: 404 Lowery ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16th 1947 (month) (day) (year)
Cemetery or crematory: C & E Lawn Cem
Location: City
18. Funeral director: Ulrich Funeral Home
Address: 2008 Orleans St
19. May 14 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 1947, at 7 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 May 1947, to 12 May 1947
and that I last saw h. IM alive on 12 MAY 1947
Immediate cause of death: Cerebral Thrombosis — DURATION: hours
Due to: Arteriosclerosis — years
Due to: Age.
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maxwell A. Mund M. D. or Coroner
Address: 417½ Eastern Ave Date signed: 13 May 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

03698

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 3 mos., 21 days
Hospital, Institution, or street address where death occurred:
Sheppard and Enoch Pratt Hospital
How long in hospital or institution? 3 yrs., 3 mos., 21 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington - 8
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2205 California St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Dr. Harry H. Donnally

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bessie Donnally
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1877

8. AGE:

Years	Months	Days	If less than one day
69	8	19	..... hrs. ..... min.

9. Birthplace: Georgetown, Kentucky (Town, county, and state)
10. Usual occupation: Physician
11. Industry or business: private practise

FATHER
12. Name: William Donnally
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Martha Scharff
15. Birthplace: Virginia

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24th 1947 (month) (day) (year)
Cemetery or crematory:
Location: Pulaski, Virginia
18. Funeral director: Joseph Gawlers' Sons
Address: 1750 Pennsylvania Ave. Washington D.C.

19. 5/23 1947 (Date received by registrar) A. H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1947 at 12 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1st 1945 to May 23 1947 and that I last saw him alive on May 22 1947.

Immediate cause of death	DURATION
Bronchopneumonia	8 days
Due to	
Due to	
Other conditions: Arteriosclerosis, generalized and cerebral (with psychosis)	7 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Jack B. Jarvis M.D.
M. D. or other
Address: Towson-4, Md. Date signed: 5-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03699

1310

CERTIFICATE OF DEATH

Reg. Dist. No. 3-0

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural - Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rural - Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: South Rolling Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie A. Dorsey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: Basil Dorsey

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1860

8. AGE: Years: 87 | Months: 4 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Milton Day

13. Birthplace: Md.

MOTHER

14. Maiden name: Sarah J. Smith

15. Birthplace: Md.

16. Informant: Mrs. Howard Garbert

Address: S. Rolling Rd. Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1947 (month) (day) (year)

Cemetery or crematory: Morgan Chapel Cem.

Location: Mt. Washington, Md.

18. Funeral director: C. Harry Weis

Address: Lyndeville, Md.

19. 5-11 1947 (Date rec'd by registrar) Harry L. Mueller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1941 to May 8 1947 and that I last saw h.e.r. alive on May 8 1947

	DURATION
Immediate cause of death: Pulmonary Embolism	1 hrs.
Due to:	
Due to: Cardio-Vascular Renal Disease	7 yrs?
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George E. Brown M. D.

Address: 803 3rd Ave Catonsville 28 Md Date signed: 5-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

05700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 403 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution? 403 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1709 N. Edison Highway
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: CALVIN T. EHRMAN

3.(b) Social Security Number: 215-09-7704

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Laura L. Ehrman

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): July 5, 1890

8. AGE: Years	Months	Days	If less than one day
56	10	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Restaurant Manager

11. Industry or business

FATHER
12. Name: Charles A. Ehrman
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Mary V. Tyte
15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Balto., Md.

18. Funeral director: Lasahn Funeral Home

Address: 7401 Belair Road, Balto. 6, Md.

19. 2 June 1947 (Date rec'd by registrar) D. L. Farber, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1947 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1946 to May 31 1947 and that I last saw him alive on May 31 1947

Immediate cause of death	DURATION
TUBERCULOSIS, PULMONARY BILATERAL, FAR ADVANCED	13 mos. plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Robert M. Culleson, M. D. or other

Address: VAH Fort Howard, Md. Date signed: 5-31-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164d

03701

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1746 Leslie Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Stephen Ferencin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Unknown 1885

8. AGE: Years: 62 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Czechoslovakia (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Andrew Ferencin
13. Birthplace

MOTHER
14. Maiden name: Anna —
15. Birthplace

16. Informant: Andrew F. Lopko
Address: 1746 Leslie ave. Dundalk.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1947 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: Baltimore Co.

18. Funeral director: Roland L. Fisher
Address: 2112 Dundalk ave.

19. 5/18/47 (Date rec'd by Registrar) 19 M Warren Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1947, at 12 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suicide by cutting throat	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 5-16-47
Where did injury occur? Dundalk (City or town) Balto (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Cut throat with knife Injured at work? No.

23. SIGNATURE: M D Davis M.D.
Dept. Medical Exam - M. D. or other
Address: Dundalk Md. Date signed: 5/17/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03702

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH:
County Baltimore
City or town Trenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto
City or town Trenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bessie L Fishpaw

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife Wm A Fishpaw
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 8-1889

8. AGE: Years	Months	Days	If less than one day
58	—	24	hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Eli D Crowther
13. Birthplace Maryland

MOTHER
14. Maiden name Cecelia R Royston
15. Birthplace Maryland

16. Informant Wm A Fishpaw
Address Upperco - Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 4/47 (month) (day) (year)
Cemetery or crematory Trenton
Location Balto Co Md
18. Funeral director Edw C Upton
Address Hampstead, Md

19. May 3 1947 (Date rec'd by registrar) C E Fonbelanne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 2 1947 and that I last saw h[illegible] alive on May 1 1947

Immediate cause of death	DURATION
Coronary Occlusion	Suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Earl E Bush M.D.
M. D. or other
Address Hampstead Md Date signed 5-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03703

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Infirmary
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 701 Baltimore Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Lemmon Foster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Milton H. Foster
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 23, 1874

8. AGE: Years	Months	Days	If less than one day
72	11	27	hrs. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Homemaker
11. Industry or business: —

FATHER
12. Name: Wm. Carver
13. Birthplace: Balto. Co. Penn

MOTHER
14. Maiden name: Priscilla Parks
15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. John W. Wheatley
Address: 701 Balto. Ave, Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23, 1947 (month) (day) (year)
Cemetery or crematory: Grace
Location: Chestnut Ridge
18. Funeral director: Landon M. Brooks
Address: Towson, Md.
19. May 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947 at 4:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1933, to May 20 1947 and that I last saw h.e.r. alive on May 20 1947

Immediate cause of death	Duration
Coronary heart disease, with occlusion	2 yrs
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: Rollin L. Hudson M.D.
M. D. or other
Address: Towson Md. Date signed: 5/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03704

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 Southland Court

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Norman Ewing Fryer

3.(b) Social Security Number [redacted]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife: Edith Green Fryer

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Jan. 18, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	13	...hrs. ...min.

9. Birthplace: Cecil Co. Maryland (Town, county, and state)

10. Usual occupation: Sales Representative

11. Industry or business: James Mining Coal Co.

FATHER — 12. Name: Wm. T. Fryer

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Arabella Ewing

15. Birthplace: Georgia

16. Informant: Mrs. N. E. Fryer

Address: 28 Southland Ct.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-4-47 (month) (day) (year)

Cemetery or crematory: Chestnut Grove

Location: Phoenix Md. (Rural)

18. Funeral director: Camden M. Brooks

Address: Sparks Md.

19. May 7 1947 (Date rec'd by registrar) By Gerald McCarthy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1947 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1947 to April 30, 1947

and that I last saw h... alive on April 30, 1947

Immediate cause of death

Coronary Occlusion — DURATION: 7 mths.

Due to: Uremia - Chronic & Hypertension — DURATION: mths.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas Green M.D. M. D. or other

Address: Towson 4 Md. Date signed 5/1/47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1947 62

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03708 8

CERTIFICATE OF DEATH

Reg. Dist. No. 420

1. PLACE OF DEATH

County: Balto. Co.

City or town: Glenarm

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Glen arm

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Rose Virginia Garrell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Harry B. Garrell

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): ~~October~~ April 23, 1873

8. AGE: Years: 74 | Months: 1 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Balto County

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Grafton Brooks

13. Birthplace: Md.

MOTHER 14. Maiden name: Sarah Canoles

15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. Virginia Kessler

Address: Glenarm, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 2 1947 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: Baltimore County

18. Funeral director: HENRY SANDER & SONS. INC.

Address: Baltimore Md.

19. 6/2 1947 L.W. Hadnut Dr. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29, 1947 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2 1944 to May 29 1947 and that I last saw her alive on May 28 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	1 Month
Due to: Hypertensive Cardio-Vascular Disease	20 yrs
Due to:	
Other conditions: Coronary Thrombosis (1945)	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D.

M. D. or other

Address: Fork, Md. Date signed: 5/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03705

170 c

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Near Fowblesburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Eugene Gesell

3.(b) Social Security Number: 213-24-9424

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1928

8. AGE:

Years	Months	Days	If less than one day
18	7	19	..... hrs. ..... min.

9. Birthplace: Carroll Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Henry Gesell

13. Birthplace: Carroll Co.

MOTHER

14. Maiden name: Dora Gesell

15. Birthplace: Carroll Co.

16. Informant: Henry Gesell

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21, 1947 (month) (day) (year)

Cemetery or crematory: Kriders

Location: Westminster, Md.

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. May 19, 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1947, at 1:45A. P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-18-'47, 19..., to 5-18-'47, 19...; and that I last saw him alive on not seen alive, 19...

Immediate cause of death	DURATION
Crushed right side of skull	Instant
Due to Crushed upper & lower jaws	"
12" laceration of rt. leg	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 5-18-'47

Where did injury occur? Reisterstown, Balto., Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Hanover Rd.

Means of injury: Automobile Acc. Injured at work? No

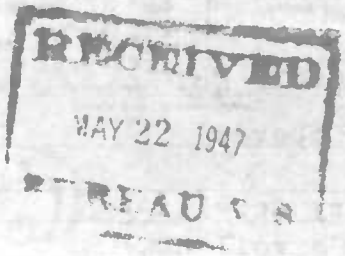
23. SIGNATURE: D. D. Caples M. D. Med. Exam
M. D. or other

Address: Reisterstown, Md. Date signed: 5-19-'47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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03706

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:

County Balto.

City or town Govans P. O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:
311 Murdock Rd.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Govans P. O.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Murdock Rd. 12
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME WILLIAM FRANCIS GETCHY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Ann Getchy

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) July 11, 1860

8. AGE: Years	Months	Days	If less than one day
86	9	25	.....hrs. .....min.

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

FATHER
12. Name John Getchy
13. Birthplace Alsaac, Lorraine

MOTHER
14. Maiden name Mary Rickle
15. Birthplace Unknown

16. Informant Mrs. Mary Ann Getchy

Address 311 Murdock Rd.

17. Burial Date thereof 5/9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 5/8 19 47 A. V. Hedrick Dir Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1947 19..... at 2:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 46 to May 5 19 47 and that I last saw h...alive on May 6 19 47

Immediate cause of death	DURATION
Respiratory Failure	24 Hrs.
Due to Heart Failure	6 Months.
Due to Arteriosclerosis Cardio-Renal Disease	10 Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? .....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Charles F. O'Donnell M.D.
M. D. or other

Address 301 York Rd Date signed 5/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03707 — 38

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since May 4, 1945

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since May 4, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 4112 Hamilton Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Patricia E. Gibson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1929

8. AGE:

Years	Months	Days	If less than one day
17	11	23	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER 12. Name: Matthew Gibson

13. Birthplace: Belfast Ireland

MOTHER 14. Maiden name: Minnie Hamilton

15. Birthplace: New Castle Co, Va

16. Informant: Personal History- Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/12/47 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5-7-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947, at 12:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1945, to May 9 1947

and that I last saw h[illegible] alive on May 8 1947

Immediate cause of death: Pulmonary tuberculosis — DURATION: April 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W A Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 5-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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8

03709

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

Street No. None
(If rural, give LOCATION)

2.(a) If veteran, name war: Civilian

3.(a) FULL NAME: HAMILTON GRAY

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Widower

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-12-61

8. AGE:

Years	Months	Days	If less than one day
85	6	11	hrs. min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Willis Gray
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elizabeth Evans
15. Birthplace: Ohio

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof May 26-47
(month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: Ellsworth Armacost

Address: 3911 Liberty Heights Ave

19. 5-26 47
(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 19 47, at 12:05a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 19 47, to May 24, 19 47 and that I last saw him alive on May 24, 19 47

Immediate cause of death	DURATION
MYOCARDIAL FAILURE,	
PULMONARY EDEMA, HYDROTHORAX	unknown
Due to Hypertrophy of Prostate with obstruction of Urethra, dilatation	
of Bladder and Ureters,	
Hydronephrosis.	unknown
Other conditions Carcinoma of Bladder	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. C. Newman, M.D.
M. D. or other

Address: V.A.H. Ft. Howard, Md. Date signed: 5-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

03710

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore.
City or town: Catonsville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
REV. Opitz Nursing Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5614 York Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward E Harp.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed.

6.(b) Name of husband or wife: Gertrude Harp.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 24, 1872

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Chauffeur.
11. Industry or business:
FATHER — 12. Name: ?
FATHER — 13. Birthplace: ?
MOTHER — 14. Maiden name: ?
MOTHER — 15. Birthplace: ?
16. Informant: Maurice D. Harp.
Address: 406 W Cold Spring Lane.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31, 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn.
Location: Balto. Co. Maryland
18. Funeral director: Chenoweth & Donovan.
Address: 3615-17 Chestnut Ave.
19. 5-31-1947 (Date rec'd by registrar) Harry F. Kuhn Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1947, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 27 1947 and that I last saw h... alive on May 27 1947

Immediate cause of death: Myocardial failure, Thrombosis — DURATION: 3 days
Due to: Generalized Arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James E Howard M. D. or other
Address: Catonsville Md. Date signed: 5/30

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C5711 P

83a

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours, app.

Hospital, Institution, or street address where death occurred:

504, Baltimore Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Pylesville

(If ontside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME

HUGH BRECKENRIDGE HEAPS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lucelle Lanius

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): March 5, 1907

8. AGE: Years	Months	Days	If less than one day
40	2	6	....hrs. ....min.

9. Birthplace: Harford County, Maryland (Town, county, and state)

10. Usual occupation: Attorney

11. Industry or business: General Practise

FATHER

12. Name: Granville Heaps

13. Birthplace: Harford County, Maryland

MOTHER

14. Maiden name: Alice Smithson

15. Birthplace: Harford County, Maryland

16. Informant: Family Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1947 (month) (day) (year)

Cemetery or crematory: Highland Cemetery

Location: Street, Harford Co., Maryland

19. Funeral director: W. Howard Webb

Address: Fawn Grove, Penna.

19. May 12 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 1947 to May 11 1947.

and that I last saw him alive on May 11, 1947

Immediate cause of death	DURATION
Apoplexy	2 hrs.
Due to: Arterio-Sclerosis and	
Hypertension-	Unk.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John L. Green Jr. M.D. M. D. or other

Address: Towson Md Date signed 5/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03712

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH

County: Balto.

City or town: Raspeburg, Balto #6 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, institution, or street address where death occurred: 1700 Summit Ave.

How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg Balto #6 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1700 Summit ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lester Edward Hein.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Anna Heins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 14 1909

8. AGE: Years 38 | Months 3 | Days 17 | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Time Keeper

11. Industry or business: Pool Parlor.

FATHER — 12. Name: Joseph Heins

13. Birthplace: Baltimore Md.

MOTHER — 14. Maiden name: Harriett Hartman

15. Birthplace: Baltimore Md.

16. Informant: Anna Heins

Address: 1700 Summit Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/3/47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Rd.

18. Funeral director: John J. Duda

Address: 2829 Hilgdon Ct.

19. 6/2/47 (Date received by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1947, at 7 1/5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1947, to May 31 1947

and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Coronary occlusion	5 min.
Due to: Rheumatic fever	25 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. McLemore M.D. M. D. or other

Address: Deputy Medical Examiner Baltimore Md. Date signed: 6/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

03713

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 305 W. Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ELEANOR C. HERBST

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John F. Herbst
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	10	...hrs. ...min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William H. Kone, Sr.
13. Birthplace: Ohio

MOTHER
14. Maiden name: Amanda J. Howard
15. Birthplace: Baltimore County, Maryland

16. Informant: John F. Herbst
Address: 305 W. Penna. Ave., Towson, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/47 (month) (day) (year)
Cemetery or crematory: Prospect Park Cemetary
Location: Towson, Maryland

18. Funeral director: Howard A. Gill
Address: 21 W. Pennsylvania Ave., Towson, Md.

19. May 13 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to May 1947 and that I last saw h...r alive on May 12 1947

Immediate cause of death: Coronary Thrombosis — DURATION: Instantly
Due to: Hypertensive Cardio-Vascular Disease — DURATION: 10 yrs
Due to: — DURATION:
Other conditions — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D. M. D. or other
Address: 730 York Rd - Towson Date signed: 5/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 03717

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Nursery Rd & Edmondson Ave
(c) Hospital or institution: Osply Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Lefeldt Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie M Hofbeing — Berber —

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1879

8. AGE: Years	Months	Days	If less than one day
68	8	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Christopher Rose
13. Birthplace Md

MOTHER
14. Maiden Name Annie J Thomas
15. Birthplace Md

16 (a) Informant Viola Krug
(b) Address 1710 Lefeldt Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 2653 Walbrook Blvd

19 (a) 1947 (Date rec'd by registrar) (b) Thomas Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1941 to May 22 1947 and that I last saw her alive on May 22 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	7
Due to	
Due to	
Other Conditions Hypertension Hemiplegia	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl P Koenig M. D.
Address 1316 W Lombard St Date signed 5/27/47

Carl P Koenig X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47c

CERTIFICATE OF DEATH

03714 P

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Simpsonville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Simpsonville, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME BENJAMIN H. HOLLAND

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife - -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/22/90

8. AGE: Years	Months	Days	If less than one day
56	11	13	..... hrs. ..... min.

9. Birthplace Simpsonville, Maryland
(Town, county, and state)

10. Usual occupation Bar Tender

11. Industry or business

FATHER
12. Name Nelson Holland
13. Birthplace Simpsonville, Howard County, Md.

MOTHER
14. Maiden name Annie Brown
15. Birthplace Anne Arundel County, Maryland

16. Informant Clinical Records, Vets.Adm.Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1947 (month) (day) (year)

Cemetery or crematory Simpsville Md

Location

18. Funeral director Mrs Katie R. Williams

Address 327 N. Schroeder St

19. 5/7 1947 J. W. Hebert Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1947, to May 5 1947 and that I last saw him alive on May 5 1947

Immediate cause of death	DURATION
BRONCHOGENIC CARCINOMA	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE W M Carmine M.D.
M. D. or other

Address Dundalk, Md. Date signed 5-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

03715

Reg. Dist. No. 33

M

1. PLACE OF DEATH

County: Balto.

City or town: Sagamore Farm - Glendon Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Nat.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: City.

City or town: Balto. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5204 Maple Ave Balto 15 Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Harry Howard Holland

3.(b) Social Security Number

218-07-3884

3884

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mary A. Holland

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 3 1878

8. AGE: Years 69 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Loch Raven Balto. Co.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Sagamore Farms

FATHER
12. Name: Albert L. Holland.
13. Birthplace: Balto Co. Md.

MOTHER
14. Maiden name: Anna E. Williamson
15. Birthplace: Balto. Co. Md.

16. Informant: Mrs Mary A. Holland

Address: 5204 Maple Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-24-47 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md.

18. Funeral director: Lazing Byers

Address: 5005 Reisterstown Rd.

19. 5/23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1947, at 1:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1947, to May 21 1947 and that I last saw him alive on May 21 1947

Immediate cause of death	DURATION
Coronary Thrombosis	10 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caplan, M.D. Med. Exam
M. D. or other

Address: Reisterstown, Md. Date signed 5-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03716

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Oliver Beach, Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Greenbank Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Melvin Holland.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Delia Grady Holland
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1872

8. AGE: Years	Months	Days	If less than one day
74	7	7	..... hrs. ..... min.

9. Birthplace ~~Md~~ Harford Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business None

FATHER
12. Name Joshua W. Holland.
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden name Amy M. Pyle
15. Birthplace Harford Co. Md.

16. Informant Melvin F. Holland
Address Wyman Park Apts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-26-1947 (month) (day) (year)
Cemetery or crematory Cathedral Cemetery
Location Baltimore Md.

18. Funeral director Flynn & Flenging
Address 1426 Light St.

19. May 21 19 47 (Date rec'd by registrar) a. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 - 19 47, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 46, to May 23 19 47
and that I last saw him alive on May 19 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	1/2 hr.
Due to Generalized Arter. io - sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas B. Bayley M.D.
M. D. or other
Address 815 Eastern Ave Date signed May 24 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C3718 P

94a

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3.(a) FULL NAME: HOOT, Paul Lewis (Also known as) HUTH, Paul Lewis

3.(b) Social Security Number: 216-10-5753

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Katherine Hoot

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): August 7, 1894

8. AGE: Years	Months	Days	If less than one day
52	9	21	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business

FATHER
12. Name: Charles Hoot
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Frances Conrad
15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records, Veterans Administration Hospital, Fort Howard, Md.
Address

17. Burial (Burial, cremation, or removal (Which?)) Date thereof: May 31/1947 (month) (day) (year)

Cemetery or crematory: London Park

Location: 3091 Frederick Ave.

18. Funeral director: Harry H. Wilhelm

Address: 4101 Edmondson Ave

19. 5/30/47 (Date rec'd by registrar) 19.... A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 19 47 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 19 47 to May 28 19 47 and that I last saw him alive on May 28 19 47

Immediate cause of death	DURATION
Coronary Occlusion with infarction	24 Hrs.
Due to: Coronary arteriosclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): .....

Means of injury: ....Injured at work?....

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M. D. CLIN. DIR.

Address: V.A.H. FORT HOWARD, MD. Date signed: 5-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03719

129

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 4 mohths, 3 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 7 years, 4 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2608 East Fayette Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Louise Hoskins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Hiram Hoskins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 23, 1886

8. AGE:

Years	Months	Days	If less than one day
60	8	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Henry Spieker

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Amelia Hottes

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/47 (month) (day) (year)

Cemetery or crematory: Lorraine Cemt.

Location: Woodlawn Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pa. Aves.

19. 5/30 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 19 47 at 2:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 19 40 to May 29 19 47 and that I last saw h... alive on May 29 19 47

	DURATION
Immediate cause of death: Peritonitis, diffuse	2½ weeks
Due to: Indigestion of foreign bodies	indefinite
Due to: Chronic myocardial insufficiency	"
Other conditions: Exploratory laparotomy (removal of foreign bodies) (Include pregnancy within 3 months of death)	2 weeks

Major findings of operation: see other conditions

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 5-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 03729

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Bowleys Quarters
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Bowleys Quarters
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bowleys Quarters Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: ERNEST M. HUGHES

3.(b) Social Security Number: 212-07-7244

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Selina Hughes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2nd, 1890

8. AGE: Years	Months	Days	If less than one day
56	11	3	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Stock Clerk

11. Industry or business: Glenn L. Martin Co.

FATHER
12. Name: Thomas H. Hughes
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden name: Annie Gold
15. Birthplace: Philadelphia, Pa.

16. Informant: Mrs. E.M. Hughes
Address: Bowleys Quarters Road

17. burial (Burial, cremation, or removal. Which?) Date thereof: May 31st/47 (month) (day) (year)

Cemetery or crematory: Moreland Memorial

Location: Taylor Ave.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. 5/29 (Date rec'd by registrar) 19 47 John R. Connolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29th 19 47 at 7:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 19 47, to May 29 1947 and that I last saw h... alive on May 29 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wk.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James H. White, M.D. M. D. or other

Address: 7601 Eastern Ave., Balto. 24, Md. Date signed: 5/29/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92a

03721

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Tanneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. 45 W. Baltimore St. (If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME JESSE G. INGRAM

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Guida Ingram 6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 2-5-1894

8. AGE: Years	Months	Days	If less than one day
53	3	23	....hrs. ....min.

9. Birthplace Ashe County, N. C. (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Robert Ingram

13. Birthplace Virginia

MOTHER 14. Maiden name Lidya Davis

15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1/47 (month) (day) (year)

Cemetery or crematory Darlington Cem

Location Darlington Md.

18. Funeral director H S Bailey (Bailey)

Address Darlington Md

19. May 29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947 at 3:55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 14 1947 to May 28 1947 and that I last saw him alive on May 28 1947

Immediate cause of death	DURATION
Aortic Stenosis	6 Months
Due to Calcification of aortic valve	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR. M.D. or other.

Address V.A.H. FORT HOWARD, MD. Date signed 5-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55d

03722

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Aella

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pleasant Hill

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Aella

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pleasant Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George I Jackson

3.(b) Social Security Number 217-03-5782

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Eliz. Jackson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1879

8. AGE:

Years	Months	Days	If less than one day
67	6	13	..... hrs. ..... min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name Henry I Jackson

13. Birthplace N.C.

MOTHER

14. Maiden name Minerva Martin

15. Birthplace N.C.

16. Informant Floyd Jackson

Address Catonsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-24-47 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore Md.

18. Funeral director H.C. Heiselbottom

Address Ellicott City Md

19. 5-22 1947 (Date rec'd by registrar) Harry D. Mullen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to May 26 1947

and that I last saw h.im alive on May 26 1947

Immediate cause of death	DURATION
Malignancy, Squamous cell with metastasis to adjacent glands	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Ernest L. Inman M.D. M. D. or other

Address Ellicott City Md Date signed 5/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c 03723 P

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Mt. Hope

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (if not in hospital): Philadelphia Rd. & Golden Ring Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1010 Riverside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2

3. (a) FULL NAME: Edmund C. Jansen Jr.

3. (b) Social Security Number: 219-01-2371

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1921

8. AGE: Years	Months	Days	If less than one day
25	5	18	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business:

FATHER — 12. Name: Edmund C. Jansen

13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Marie Thiess

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Marie Jansen

Address: 1010 Riverside Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22, 1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore

18. Funeral director: John R. Kenny

Address: 1242 Leeds Terrace-Arbutus, Md.

19. 5-21-47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1947, to May 18 1947.

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fracture cervical vertebra, [illegible]	
Due to: Concussion brain	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 5/18/47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public Road.

Means of injury: Auto. collision Injured at work? No.

23. SIGNATURE: M. McCormack M.D.

M. D. or other: Deputy Medical Examiner

Address: Towson, Md. Date signed: 5/19/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(13)a

03724

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 11 mo. 14 da.

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 7 yrs. 11 mo. 14 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2024 E. Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME

Anna Kramer Josephson

3.(b) Social Security Number

-

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Hyman Josephson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 8, 1880

8. AGE: Years	Months	Days	If less than one day
66	7	23	hrs. min.

9. Birthplace: Latvia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Stanley Kramer
13. Birthplace: Latvia

MOTHER
14. Maiden name: Molly ?
15. Birthplace: Latvia

16. Informant: Hospital Records

Address: Catonsville 28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-1-47 (month) (day) (year)

Cemetery or crematory: SHAAREI ZION

Location: ROSEDALE Conn.

18. Funeral director: So. LEVINSON & BROS

Address: 1124-26 W NORTH AVE

19. 5-1- 19 47 (Date rec'd by registrar) Harry L. Hoffman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 19 47 at 1:15a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 19 39 to May 1, 19 47 and that I last saw her alive on May 1, 19 47

Immediate cause of death	DURATION
Chronic Myocardial insufficiency	indef.
Due to: Anemia, severe, etiology unknown. 738	indef.
Due to: Chronic cardiovascular renal disease.	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk
Isadore Tuerk, M.D.

Address: Catonsville 28, Md. M. D. or other

Date signed: 5/1/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52 A

03725

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

near Winans Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. near Winans Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Frank Kalb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma H. Kalb

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): October 22, 1859

8. AGE:

Years	Months	Days	If less than one day
87	6	12	....hrs. ....min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: John Henry Kalb

13. Birthplace: Baltimore County, Md.

MOTHER

14. Maiden name: Mary E. Weidemeyer

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Milton Reynolds

Address: Randallstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: E. W. Pennington

Address: 4510 Liberty Heights Ave.

19. 5/7/47 (Date rec'd by registrar) 1947 Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947 at 4.25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 3, 1947, to May 4, 1947

and that I last saw him alive on May 4th, 1947

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: ~~Harrisonville, Md.~~ Randallstown Date signed 5/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a 03726

Reg. Diat. No. 30

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information correctly and legibly. Additional information especially important. Physicians: please write the causes of death clearly and legibly. Furnished from replacement cert. sent in by Dr. 7/18/47 ams.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yearsll months 9 days

Hospital, institution, or street address where death occurred:
Spring Grive State Hospital

How long in hospital or institution? 28years, 11 months 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 326 ~~St.~~ Paul Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Gustave Kalben

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 9 1878

8. AGE: Years	Months	Days	If less than one day
68	9	16	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William Kalben
13. Birthplace: Germany

MOTHER
14. Maiden name: Carolina A. Tok
15. Birthplace: Balto. Md.

16. Informant: Harry C. Kalben 6 57 99

Address: 701 St. Paul St. So 4w

17. Burial (Burial, ~~cremation~~, or removal, which?) Date thereof 5/27/47 (month) (day) (year)

Cemetery or ~~crematory~~: London Park

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 127 St. Paul St.

19. may 27 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 1947 19 at 2:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1928 19 to May 25, 1947 19 and that I last saw h... im alive on May 25, 1947 19

Immediate cause of death	(due to chronic	DURATION
	Chronic myocarditis (malnutrition)	Indefinite
Due to	Right lower bronchopneumonia	24 hours
Due to	Mesenteric thrombosis	23 days
	Chronic interstitial nephritis,	
Other conditions	second stage	years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk M. D. (M. D. or other)

Address: Catonsville, 28, Md. Date signed 5/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03727 42

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Relay, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3-10-47

Hospital, institution, or street address where death occurred:
3-10-47

How long in hospital or institution? Relay Sanitarium 58 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 Overland Avenue, Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME
James John Kane

3. (b) Social Security Number
220-20-6242

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

Mother
6.(b) Name of husband or wife: Marion K. Kane

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1922

8. AGE: Years	Months	Days	If less than one day
24	7	27	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Patrick Henry Kane
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Marion Keys
15. Birthplace: Baltimore, Md.

16. Informant: Bro. Dr. Harry F. Kane
Address: 1501 Northwick Road, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/10/47 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: W/S Frederick Rd.

18. Funeral director: W. A. E. Duppe & Sons

Address: Lombard & Ann Sts.

19. 5-9-47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 19 47, at 5:[illegible] P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-10-47 19, to 5-7-47 19 and that I last saw him alive on 5-7-47 19

	DURATION
Immediate cause of death: Cerebral hemorrhage	Five minutes
Due to: Convulsive seizures	Several years
Due to: Undetermined etiology	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis P. Tumbry M.D.
M. D. or other

Address: Relay, 27, Md. Date signed 5/7/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 03728

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Sparrows Pt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 C St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas B Kellow

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife: Mary Kellow
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 15 1863

8. AGE: Years: 83 Months: 11 Days: 26 If less than one day: hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER
12. Name: William Kellow
13. Birthplace: Eng

MOTHER
14. Maiden name: Mary Paul
15. Birthplace: Eng

16. Informant: Mrs H D Elyard
Address: 511 C St Sparrows Pt

17. (Burial, cremation, or removal. Which?) Removal Date thereof: May 14/47 (month) (day) (year)
Cemetery or crematory: St Johns Luth Cem
Location: Bangor Pa

18. Funeral director: Veland Tufnel Home
Address: 2008 Orleans

19. (Date rec'd by registrar) May 12 1947 Dawson L. Harbor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947 at 1:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946 to May 12 1947
and that I last saw him alive on May 11 1947

Immediate cause of death	DURATION
Cardiac Failure	1 week
Due to Hypertensive Arteriosclerotic Vascular disease	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dawson L. Harbor M. D. or other
Address: Sparrows Point, Md. Date signed: 5/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 03729

CERTIFICATE OF DEATH

Reg. Diat. No. 34

1. PLACE OF DEATH:
County: Baltimore
City or town: Upperco Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, Institution, or street address where death occurred:
New White House
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Baltimore
City or town: Upperco, Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: White House
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Lewis Kemp.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Lillie May Kemp
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Nov. 16 1868

8. AGE: Years	Months	Days	If less than one day
78	6	4.	...hrs. ...min.

9. Birthplace: Mt Zion, Balto Co. Md.
(Town, county, and state)
10. Usual occupation: Wheelwright + Blacksmith
11. Industry or business: Blacksmith.
FATHER 12. Name: Alfred Kemp
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Wilhelm
15. Birthplace: Maryland
16. Informant: Mrs John L. Kemp
Address: Upperco, Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof May 23/47 (month) (day) (year)
Cemetery or crematory: West Baptist
Location: Balto Co. Md
18. Funeral director: Edco Shipley
Address: Hampstead Md
19. May 22 1947 (Date rec'd by registrar) C. E. Fowble M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1947, to May 20 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Urinary Tract Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury — Injured at work?

23. SIGNATURE: Joseph E. Bennett M. D. or other
Address: Hampstead Md Date signed 5-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

03730

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Balto.
City or town Govans P. O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
541 Dunkirk Rd.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Govans P. O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 541 Dunkirk Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME NANNIE CRANE KENT

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Horace C. Kent
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 28, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	24	..... hrs. ..... min.

9. Birthplace New Albany, Ind.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John C. Crane
13. Birthplace Mass.

MOTHER
14. Maiden name Elizabeth Crane
15. Birthplace Mass.

16. Informant Mr. Millard C. Kent
Address 541 Dunkirk Road

17. Cremation Date thereof 5/14/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. May 14 19 47 C. W. Beard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to May 12 1947
and that I last saw h.. alive on May 12 1947

Immediate cause of death	DURATION
Carcinoma of Lung	6 mo.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. J. Chalfant M.D. M. D. or other
Address 6710 York Rd. Date signed May 15 1947

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

03731

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 14 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sylvester V. King

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Minerva Nelson King

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): December 31, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	8	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Boiler maker

11. Industry or business: Factory

FATHER
12. Name: Johns George King
13. Birthplace: Maryland

MOTHER
14. Maiden name: Josephine Ritter
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12-47 (month) (day) (year)
Cemetery or crematory: St. Thomas
Location: Balto Co.

18. Funeral director: J. F. Elene. Sons
Address: Reisterstown Md

19. 5-12 1947 (Date rec'd by registrar) Henry H. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947, at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1947, to May 9 1947 and that I last saw h...im...alive on May 9 1947

Immediate cause of death	DURATION
Chronic cardiovascular-renal disease	indefinite
Due to: Uremia	4 days
Broncho pneumonia	24 hours
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. M. D. or other

Address: Catonsville-28, Md. Date signed 5-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03732

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years, 3 months, 4 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 16 years, 3 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 803 Chauncey Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Nathan Kitt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Rose Gashem

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 14, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	18	hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: Tailoring

FATHER
12. Name: Morris Kitt
13. Birthplace: Russia

MOTHER
14. Maiden name: Esther Magullen
15. Birthplace: Russia

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-4-47 (month) (day) (year)

Cemetery or crematory: Hebrew Cemetery

Location: Philad. Rd. Balto. Md. 8

18. Funeral director: Jack Lewis Inc

Address: 1400 Eutaw Place

19. 5-2 1947 (Date rec'd by registrar) Harry Ly Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1947, at 7-30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Cardio vascular renal disease	
Due to:	
Other conditions: sudden death	
(Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: Geo M. Kieffer Jr. Examining M.D. or other

Address: 1010 Leadenhall Date signed: May 2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

03733

P

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Bucks School House Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bucks School House Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Gertrude C Krastel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Peter J Krastel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 25 1901

8. AGE:

Years	Months	Days	If less than one day
45	8	18	..... hrs. ..... min.

9. Birthplace: Baltimore County Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: John H Coxon
13. Birthplace: Baltimore County

MOTHER
14. Maiden name: Elizabeth Langeman
15. Birthplace: Baltimore City

16. Informant: Mr Peter J Krastel
Address: Buck School House Rd #430

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16 47 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd Balto 6 Md

19. May 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1947 12:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1946 to May 13 1947 and that I last saw her alive on May 13 1947

	DURATION
Immediate cause of death: Chronic interstitial Nephritis	4 yrs
Due to: Diabetes	1 yr
Due to: My condition & Insufficiency	2 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edward H Benson M. D. or other
Address: 1 W. Orchard Date signed: 5/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Edw. Bruson.

1 Dr Overlea Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

CERTIFICATE OF DEATH

Reg. Dist. No. 6373435

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Baltimore

City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 m. West of Freeland.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Benson Krout.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Luretta Jane Baker

6.(c) If alive, give age: 85. years

7. Birth date of deceased (mo., day, yr.): January 14, 1860.

8. AGE:

Years	Months	Days	If less than one day
87	4	3	hrs. min.

9. Birthplace: New Freedom, Pa. R.D.
(Town, county, and state)

10. Usual occupation: Carpenter (Retired)

11. Industry or business

FATHER
12. Name: Joseph Krout.
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Liza Lowe.
15. Birthplace: Penna.

16. Informant: Mrs. Daniel Wilson
Address: Freeland, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Freeland, Balto. Co. Md.

18. Funeral director: Jacob Hartenstein

Address: New Freedom, Pa.

19. May 18 1947 (Date filed by registrar) Elizabeth L. Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1947; at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to May 17 1947 and that I last saw him alive on May 15 1947

Immediate cause of death	DURATION
Uremia	
Due to	
Due to	
Other conditions: Arteria-sclerosis & Chronic nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. M. Fraser M. D. or other

Address: Parkton, Md. Date signed 5/17/47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1206 03735 Reg. Dist. No. 30

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Hitchcock Nursing Home
How long in hospital or institution? 15 Arbutus Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3601 4th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Virginia Kurowska

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27, 1930

8. AGE: Years	Months	Days	If less than one day
16	11	5	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER 12. Name: Frank Kurowska
13. Birthplace: Baltimore, Md

MOTHER 14. Maiden name: Lillian Andrysiak
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Lillian Foster
Address: 3601 4th Ave. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6, 1947 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Md.

18. Funeral director: William J. Tickner & Sons
Address: North & Pennsylvania Aves

19. 5-5-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1947, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1947, to May 2, 1947
and that I last saw her alive on April 30, 1947

Immediate cause of death	DURATION
Ulcerative Colitis, Chron	8 wks.
Due to: Hystory of repeated attacks of	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 20 20 1/2 E. Chase St. Date signed: 5-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03736

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Anneslie
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
812 Regester Ave.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Anneslie, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 812 Regester Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ----------

3.(a) FULL NAME Emma L'Allemand

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife ----------
6.(c) If alive, give age --- years
7. Birth date of deceased (mo., day, yr.) Unknown - Approx. 1867

8. AGE:	Years	Months	Days	If less than one day
Over	80	---	---	--- hrs. --- min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation None
11. Industry or business ----------

FATHER
12. Name Charles L'Allemand
13. Birthplace Germany

MOTHER
14. Maiden name Amelie Muehler
15. Birthplace Germany

16. Informant Mrs. Louis L. Judge
Address 510 Evesham Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/47 (month) (day) (year)
Cemetery or crematory ##### Woodlawn
Location Woodlawn, Md.

18. Funeral director H. H. Mears and Son
Address 805 N. Calvert St.

19. 5/30 19 47 (Date rec'd by registrar) H. W. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 19 47, at 4.P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 47, to 5/28 19 47 and that I last saw h. alive on 5/28 19 47

Immediate cause of death	DURATION
Hypertension Coronal Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. W. Hebert M. D. or other
Address 5733 Hartford Rd Date signed 5/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03737

CERTIFICATE OF DEATH

Reg. Dist. No. 46 1

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 Township
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Ambrose Le Brun

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mellie Le Brun
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Aug 29 - 1873

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Caretaker
11. Industry or business Retired

FATHER
12. Name
13. Birthplace France

MOTHER
14. Maiden name Jennie Bradford
15. Birthplace Md

16. Informant Chas Le Brun
Address 27 Township

17. Remove (Burial, cremation, or removal. Which?) Date thereof May 19 - 47 (month) (day) (year)
Cemetery or crematory Beth Oseh Cem
Location Hampstead
18. Funeral director Ulrich Funeral Home
Address 2008 Orleans St
19. 5/17/47 (Date rec'd by registrar) J M Kammerer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1947, at 10-15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947, to May 15 1947
and that I last saw h.... alive on May 8 1947

	DURATION
Immediate cause of death Coronary Occlusion	5 min.
Due to A-S-C-V Disease	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J J Bowers M.D.
M. D. or other
Address Dundalk-Md Date signed 5/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03738

Reg. Dist. No. 59

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: 424 Bloomsbury Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 424 Bloomsbury Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Hattie Armenia Lindsay

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Edwin George Lindsay 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	23	hrs. min.

9. Birthplace: Baddeck Forks, Canada (Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Retired

FATHER — 12. Name: William A. Rice

FATHER — 13. Birthplace: Cape Breton Co. Nova Scotia Canada

MOTHER — 14. Maiden name: Mary Ann

MOTHER — 15. Birthplace: Cape Breton Co. Nova Scotia Canada

16. Informant: J. E. Lindsay

Address: 424 Bloomsbury Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: Easton Sons

Address: 608 Frederick Ave. Catonsville

19. 5-5-1947 (Date rec'd by registrar) Harry D. Keller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1947, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1 1947 to 5/5 1947 and that I last saw her alive on 5/4 1947

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Myocardial insufficiency	2 weeks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Reiter M. D. or other

Address: 3408 Windsor Ave. Date signed: 5/6/47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

03739

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore County
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred:
2123 Gwynn Oak Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore Co
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2123 Gwynn Oak Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Marion Grace Line

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

8.(b) Name of husband or wife: John Edward Line
8.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Oct. 3 1878

8. AGE: Years: 68 | Months: 7 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Baltimore City Md (Town, county, and state)
10. Usual occupation: House Keeper
11. Industry or business: Own Home

FATHER
12. Name: Samuel W. McDonnal
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Sophronie Haney
15. Birthplace: Baltimore (?) Md

16. Informant: Mrs. John Edward Line
Address 2123 Gwynn Oak Avenue
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-21-47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18. Funeral director: C. Howard Strong
Address 3207 W. North Ave
19. 5-(5 1947) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947 at 9 42 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947 to May 17 1947 and that I last saw h[illegible] alive on May 17 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to Arterio-sclerosis	uncertain
Due to Arterial Hypertension	Uncertain
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation
no operation Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joshua H. Amacost M.D.
Address 649 Windsor Mill Rd Baltimore-7 Md M. D. or other Date signed 5/17/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03740 P

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH

County: Baltimore

City or town: Lutherville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Lutherville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Front Ave & Lincoln Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur John Lomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elena Perez

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 7, 1879

8. AGE: Years	Months	Days	If less than one day
67	8	10	hrs. min.

9. Birthplace: Montreal Canada (Town, county, and state)

10. Usual occupation: Physician

11. Industry or business

FATHER 12. Name: Henry T. Lomis

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Jane Walton

MOTHER 15. Birthplace: England

16. Informant: Mrs. Elena Perez Lomas

Address: Lutherville Md

17. Mausoleum (Burial, cremation, or removal. Which?) Date thereof May 21 1947 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: North Ave & Greenmount Ave.

18. Funeral director: John O. Mitchell & Sons

Address: 400 Eutaw Place

19. 5-19-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947, at 8.45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Heart disease, chronic myocarditis	4 yrs
Due to: Hypertension	4 yrs +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rollin C. Hudson MD DMD (M. D. or other)

Address: Towson Md Date signed 5/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M age

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BC 93d

03741

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 111 Burnett Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John Lucke

3. (b) Social Security Number:

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Dixie Lucke deceased

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 1898 July 22, 1898

8. AGE: Years 48 Months ? Days ? If less than one day ... hrs. ... min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual occupation: Huckster

11. Industry or business: self-employed

FATHER 12. Name: Joseph J. Lucke

13. Birthplace: Balto. Md

MOTHER 14. Maiden name: Millie Cooney

15. Birthplace: Balto. Md

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24/47 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Old Frederick Rd

18. Funeral director: Kraus Funeral Home

Address: 1716 S. Charles St.

19. 5/23 19 47 [signature] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 19 47, at 2:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: apoplexy

Due to:

Due to: Cardio vascular disease

Other conditions: sudden death Inquiry

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Geo. S. M. Kieffer, Dep. Med. Ex. for Balto. Co. — M. D. or other

Address: 1010 Leeds ave. Date signed 5-21-47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

03742 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
113 Shadynook Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 113 Shadynook Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Thomas J. MacDermott

3. (b) Social Security Number: 217-05-1329

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Anna Lee
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 24th 1874

8. AGE: Years	Months	Days	If less than one day
73	1	12	hrs. ..... min.

9. Birthplace: Delaware County, Pennsylvania (Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business: Retired

FATHER
12. Name
13. Birthplace: Ireland

MOTHER
14. Maiden name
15. Birthplace: Ireland

16. Informant: James B. MacDermott, Sr.
Address: 113 Shadynook Court, Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/8/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.
Address: 1217 St. Paul Street

19. 5/7/47 (Date rec'd by registrar) A. O. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1947, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946, to May 6 1947
and that I last saw h.. alive on May 3 1947

Immediate cause of death	DURATION
Myocardial Failure	3 Wks
Due to: Cardio-Vascular Disease	10 Mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. P. Van Schaick M.D.
M. D. or other
Address: 818 Edmondson Ave Date signed: 5/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 037431

1. PLACE OF DEATH:
County Balto Co.
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Dundalk - Md Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 89 Avalon Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Francis H marine.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of ~~husband~~ or wife Ellie E marine.
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77		25	hrs. min.

9. Birthplace Dor Co. (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business

FATHER
12. Name Fa Eduard marine
13. Birthplace Dor Co

MOTHER
14. Maiden name Dont know.
15. Birthplace

16. Informant William F marine
Address 89 Avalon ave. Dundalk md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26 1947 (month) (day) (year)
Cemetery or crematory Hill Crest
Location Federalsburg md.

18. Funeral director J J Frenchtom & Son.
Address Federalsburg md.

19. 5/24 1947 (Date rec'd by registrar) Milton M. Smullen Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 24 1947, at 5.07 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 17 1947 to MAY 24 1947
and that I last saw h. im alive on MAY 22 1947

Immediate cause of death	DURATION
CEREBRAL THROMBOSIS	1 WEEK
Due to HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIO VASC. DIS.	?
Due to CHRONIC NEPHRITIS	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stephen C. Mockridge M.D. M. D. or other
Address 6714 Holabird Ave Date signed May 24, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03744

P

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 232 Colgate Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ella C. Markel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife: James Markel
6.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): Apr 17th 1873

8. AGE:

Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Noah Gantz
13. Birthplace: Pa

MOTHER
14. Maiden name: Leah Butt
15. Birthplace: Pa

16. Informant: Mrs Inez Dunnigan
Address: 2901 Arlington Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6 (month) (day) (year)
Cemetery or crematory: Western Cemetery
Location: City

18. Funeral director: Ulrich Funeral Home
Address: 2108 Orleans St

19. 5/6/47 (Date rec'd by registrar) D. W. Helrich M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3rd 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1947 to May 3 1947 and that I last saw h.. alive on April 28 1947

Immediate cause of death: Hypertension C-V-R- Disease

DURATION
10 yrs
—

Due to: Arteriosclerosis

Due to:

Other conditions: Ulcer L. Arm; Gastritis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Boavers M.D. M. D. or other
Address: 2 Dundalk Ave Date signed: 5/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03745 P

131a

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54yr. 1mo- 21 day.
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 54yr. - 1 mo - 21 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1228 W. Cross St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Lena Marshall

3.(b) Social Security Number
none

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed.
6.(b) Name of husband or wife: Thomas A. Marshall (deceased)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan. 7, 1864
8. AGE: Years 83 | Months 4 | Days 11 | If less than one day ..... hrs. ..... min.
9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: house wife
11. Industry or business
12. Name of father: August Hunt
13. Birthplace of father: Germany
14. Maiden name of mother: Frederica Kaufman
15. Birthplace of mother: Germany
16. Informant: Records Spring Grove State Hosp.
Address: Catonsville 28, Md.
17. Burial, cremation, or removal: Burial — Date thereof: May 20. 1947 (month) (day) (year)
Cemetery or crematory: Schwartz Cem
Location: Balto Md
18. Funeral director: Robt C. & B. M. Walters
Address: Pratt & Stricker Sts
19. (Date rec'd by registrar) 5-19-1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947 at 2.40 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1946 to May 18 1947 and that I last saw h. alive on May 18 1947

	DURATION
Immediate cause of death: Chronic myocarditis	2+ yr.
Due to:	
Due to:	
Other conditions: Generalized arteriosclerosis 2+ yr. Chronic interstitial nephritis 2+ yr.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Gustav Hunt M. D. or
Address: Spring Grove Hospital Catonsville 28 Md
Date signed: May 18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly and fully. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18 | 186a

CERTIFICATE OF DEATH

03746 47 143

Reg. Diat. No.

1. PLACE OF DEATH:

County Balto.

City or town Parkville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 3015 Putty Hill ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Balto

City or town Parkville (If outside city or town limits, write RURAL and give nearest town)

Street No. 3015 Putty Hill ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph H. Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1900

8. AGE: Years	Months	Days	If less than one day
46	9	28	hrs. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Joseph Miller

13. Birthplace Balto. Co., Md.

MOTHER 14. Maiden name Eliz. Borisch

15. Birthplace Balto., Md.

16. Informant Mrs. Andrew Miller,

Address 3009 Putty Hill Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof May 17 - 1947 (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto., Md.

18. Funeral director Loudenslager Funeral Home

Address 7401 Belair Road

19. May 15 1947 Mrs A. L. Reisinger (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 6A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 15 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Strangulation by medulla.	
Due to Fracture Base of Skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/15/47

Where did injury occur? Parkville (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Automobile accident; Injured at work? No.

23. SIGNATURE J. M. Carmine, M.D. Deputy Medical Examiner (M. D. or other)

Address Towson, Md. Date signed 5/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

03747 32

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 13 Walker Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Katherine C. Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: Harry F. Miller

8.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): July 18, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	5	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Gerwig

FATHER — 13. Birthplace: Baltimore Maryland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace

18. Informant: Harry F. Miller

Address: 13 Walker Ave. Pikesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26, 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Woodlawn, Maryland

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. May 23 1947 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19th 1947, to May 23rd 1947

and that I last saw h alive on May 22nd 1947

Immediate cause of death	DURATION
Acute Lymphoctic Leukemia	2 mons.
Due to: Chronic Pancreatitis.	4 mons.
Due to:	
Other conditions: Chronic Myocarditis.	2 mons.

(Include pregnancy within 3 months of death)

Major findings of operations: Chronic Pancreatitis Splenomegalis Date of op. 3/22/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jane C. Miller M.D. M. D. or other

Address: Pikesville, Md. Date signed: 5/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

112 03748

Reg. Dist. No. 41

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH.
County: Baltimore
City or town: Dundalk - 22
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 years
Hospital, institution, or street address where death occurred:
2015 Dundalk Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk - 22
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2015 Dundalk Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Michael Jacob Miller

3.(b) Social Security Number
213-09-1033

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Miller
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 20 Oct. 1892

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Pipe-fitter
11. Industry or business: Steel Plant
FATHER 12. Name: John Miller
13. Birthplace: Poland
MOTHER 14. Maiden name: Augusta Miller
15. Birthplace: Poland
16. Informant: Mrs. Frances Miller
Address: 2015 Dundalk Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-13th 1947 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: Germans Hill Road
18. Funeral director: Lee G. Crook
Address: 1701-03 N. Patterson Park Ave
19. 5/12 1947 (Date rec'd by registrar) Milton M. Smullen Registrar
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 May 1947 at 2 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 April 1947 to 4 April 1947 and that I last saw h. alive on 4 April 1947 (sent to hospital 19)

Immediate cause of death	DURATION
Heart failure	2 weeks.
Due to: Bronchial asthma	9 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. W. Dowd M.D.
M. D. or other
Address: 8 Liberty Parkway Date signed: 10 May '47
M. Mckenrone Dep.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

03749

Reg. Diat. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1947 75 2

1. PLACE OF DEATH:
County: Baltimore
City or town: Monkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Monkton - Mason Rd -
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Samuel Elmer Miller

3.(b) Social Security Number: 220-22-7921

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Edna Elliott
6.(c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.): Mar. 12, 1872

8. AGE: Years	Months	Days	If less than one day
75	3	12	...hrs. ...min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Rural Mail Carrier - Retired
11. Industry or business: Machinist Helper - Blacksmith
FATHER 12. Name: Thomas J. Miller
FATHER 13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Victoria Holmes.
MOTHER 15. Birthplace: Balto. Co. Md.
16. Informant: Mrs. S. E. Elmer
Address: Monkton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27 1947 (month) (day) (year)
Cemetery or crematory: St. James
Location: Monkton Md.
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.
19. May 27 1947 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1947 at ...M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1946 to May 24 1947
and that I last saw h.. ...alive on May 24 1947

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ...Injured at work?

23. SIGNATURE: G. M. France M. D. or other
Address: Parkton, Md. Date signed 5/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03750

Reg. Dist. No. XX

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1637 Division Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

WALTER T. MILLS

3.(b) Social Security Number
Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs. Fleeta Mills

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 4/20/98

8. AGE: Years	Months	Days	If less than one day
49	1	10	..... hrs. ..... min.

9. Birthplace: Snow Hill, Md.
(Town, county, and state)

10. Usual occupation: Gov't Employee

11. Industry or business

FATHER
12. Name: George Mills
13. Birthplace: Snow Hill, Maryland

MOTHER
14. Maiden name: Josephine Coston
15. Birthplace: Snow Hill, Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-3-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Fredrick Ave.

18. Funeral director: Charles R. Law

Address: 802 Madison Ave

19. 6/2 1947 A. L. Pedicord Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30, 1947 19..... at 12:50 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 19.47, to May 30 1947 and that I last saw him alive on May 30 1947

Immediate cause of death	DURATION
Hypertensive myocardial failure	7 days plus
Due to: Chronic nephritis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON M.D. CLINICAL DIRECTOR

Address: VAH Fort Howard, Md. Date signed: 5-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

State of Maryland
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 30 P

03751

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Anna Elizabeth Minnick

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4- 1874

8. AGE: Years	Months	Days	If less than one day
73	4	8	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Adam Snyder
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary-
15. Birthplace: Maryland

16 (a) Informant: Marie E. Timmons
(b) Address: 701 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 (month) (day) (year)
(c) Cemetery or crematory: Cemetery
Location: Baltimore

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) May 13 1947 (Date rec'd by registrar) (b) a. W. Bedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1947, at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1946, to 5/12 1947, and that I last saw h er alive on 5/11 1947

Immediate cause of death	Duration
Diabetes mellitus	
Due to	
Due to	
Other Conditions Arteria sclerotic. Cardio-renal vascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Klaus Langlein M. D.
Address 40 N. Payson St. Date signed 5/12/47

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92C

P

CERTIFICATE OF DEATH

Reg. Dist. No. 03758 D

1. PLACE OF DEATH:
County 16 Trusting ave Catonsville Md
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4½ months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Late Mamie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation:

11. Industry or business: None

FATHER
12. Name: Adolph Morris
13. Birthplace: Germany

MOTHER
14. Maiden name: Sarah Goldstrom
15. Birthplace: Germany

16. Informant: Mrs Rae Block
Address: 3611 Labyrinth Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1947 (month) (day) (year)
Cemetery or crematory: Hebrew Friendship Cem
Location: 3600 E Baltimore St

18. Funeral director: Sol Levinson & Bros
Address: 1124-1126 W North Ave

19. 5/5 47 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17 1946, to May 4 1947 and that I last saw h... alive on May 4 1947

Immediate cause of death	DURATION
Auricular Fibrillation	7 days
Due to Mitral + Aortic Insufficiency	?
Due to Rheumatic Endocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Nelson K. Gallagher M.D. M. D. or other
Address Catonsville 28 Md Date signed 5-5-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

03753

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Monkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County: Wayne
City or town: Wooster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cleveland Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Jessie May Overholt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John D. Overholt
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): March 17, 1892

8. AGE: Years	Months	Days	If less than one day
55	1	24	..... hrs. ..... min.

9. Birthplace: Bellevue, Ohio
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Frank C. Wickwire
13. Birthplace: Bellevue, Ohio

MOTHER
14. Maiden name: Ivydelle Tennery
15. Birthplace: Clyde, Ohio

16. Informant: Mrs Dora Johns
Address: Monkton, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 5/9/47 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Greenmount Ave. Balto. Md

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 5-8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 May 1947, at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 April 1947 to 6 May 1947 and that I last saw h.r alive on 6 May 1947

Immediate cause of death	DURATION
Cancer of Ovary	10 months
Due to	
Due to	
Other conditions: Anemia, secondary	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kees M. D. M. D. or other
Address: Cockeysville, Md. Date signed 6 May 1947

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

03754

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 15 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville-28 (If outside city or town limits, write RURAL and give nearest town)

Street No. Spring Grove State Hospital (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Logan James Owens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Myrtle Owens 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1914

8. AGE: Years	Months	Days	If less than one day
33	?	?	hrs. min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: Attendant

11. Industry or business: State Hospital

FATHER 12. Name: ?

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 24, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Denmark, South Carolina

18. Funeral director: Harry H. Wetzler

Address: 4101 Edmondson Ave.

19. 5-24- 1947 (Date rec'd by registrar) Harry H. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 47 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute heart failure (acute dilatation)	½ hour?
Due to: Sub-acute diffuse glomerular nephritis	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis McKieffer Dep Med Exam Balto M. D. or other

Address: 1010 Leeds ave Date signed: 5-23-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03755

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Monkton, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Monkton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Myers Pearce Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Walter Perdue

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Bertie (Hope)

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Dec. 18 1879

1846 67 1879

8. AGE: Years	Months	Days	If less than one day
67	4	13	....hrs. ....min.

9. Birthplace: Balto. Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Walter Perdue

13. Birthplace: Monkton, Md.

MOTHER 14. Maiden name: Louisah Nelson

15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. Walter Perdue

Address: Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1947 (month) (day) (year)

Cemetery or crematory: St. James

Location: Monkton, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. May 2 1947 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1947 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 to May 1 1947

and that I last saw h.. alive on April 30 1947

Immediate cause of death: Chronic Valvular heart disease — DURATION: 10 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Milner Bortner M. D.

M. D. or other

Address: White Hall Date signed: May 2, 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

03756

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 11 months 4 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 year, 11 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2012 Oakington Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Annie Peyton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Separated

6.(b) Name of husband or wife: Joseph E. Peyton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 11, 1890

8. AGE: Years	Months	Days	If less than one day
57		29	hrs. min.

9. Birthplace (town, county, and state): Freeland, Maryland

10. Usual occupation: Housewife

11. Industry or business: None

FATHER 12. Name: Wm. F. Slenbaker

FATHER 13. Birthplace: Baltimore Co. Maryland

MOTHER 14. Maiden name: Catherine A. Tracey

MOTHER 15. Birthplace: Baltimore Co. Maryland

16. Informant: Hospital records

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn Md

18. Funeral director: Chenoweth & Donovan.

Address: 3615 17 Chestnut Ave.

19. 5-10 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947, at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1945 19 to May 10 19 47 and that I last saw her alive on May 10, 1947 19

Immediate cause of death	DURATION
Cerebral hemorrhage	17 hours
undetermined etiology	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. (M. D. or other)

Address: Catonsville 28, Md. Date signed: 5/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly, fully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03757

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 1 mo., 15 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 3 yrs., 1 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Allendale Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mr. Edward W. Posey

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 10, 1904

8. AGE: Years	Months	Days	If less than one day
42	4	23	hrs. min.

9. Birthplace: St. Mary's Co., Md. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: Edward H. Posey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mildred Gardner
15. Birthplace: Unknown

16. Informant: Edward W. Posey
Address: 709 Allendale Rd., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6, 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Reisterstown Rd., Balto. Co., Md.

18. Funeral director: Harry H. Witzke
Address: 4101 Edmondson Ave., Balto., Md.

19. May 3, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 1947, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1944, to May 3, 1947 and that I last saw him alive on May 3, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs. 3 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. M. D., or other
Address: Mount Wilson, Md. Date signed: 5/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

State of Maryland
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 940

Registered No. 42 P

Balto County

1. PLACE OF DEATH:
(a) ~~Baltimore City~~ State, Maryland
(b) Street address 2836 Pennsylvania Avenue
(c) Hospital or institution: Rosemont
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED: 03758
(a) State Florida (b) County
(c) City or town St Petersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 S. Tangerine Avenue
(If rural give location)
(e) Citizen of foreign country? Citizen (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Potter

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Christine Potter
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) Oct 14 1879
8. AGE: Years 67 | Months 7 | Days 0 | If less than one day: hr. min.
9. Birthplace Queens Anne Town Md.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business retired

FATHER
12. Name Thomas Potter
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ford
15. Birthplace Maryland

16 (a) Informant Kenneth Richard Potter
(b) Address 3011 Hammons Ferry Rd. Lawrence
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 17 (day) 47 (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md
18 (a) Funeral director Wilson & Sons
(b) Address 1211 E Fort Ave
19 (a) May 14 1947 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 14 - 1947, at 5 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from May-13 1947 to May-14 1947, and that I last saw h. alive on May-13-1947.

	Duration
Immediate cause of death: acute heart failure	11 hours
Due to: coronary - sclerosis	
Due to:	
Other Conditions: General arterio-sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walther H. Sommerfeldt M.D.
Address 2708 Hollins Ferry Rd Baltimore 30, Md. Date signed 5/14/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a

03759

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

Harlem Lodge

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1719 Ashburton St.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME

Mira Eileen Pritchett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14, 1928

8. AGE: Years	Months	Days	If less than one day
18	11	29	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Miriam G. Pritchett

Address: 1719 Ashburton St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15/47. (month) (day) (year)

Cemetery or crematory: Mt. Olivet M. E. Cemetery

Location: St. Michaels, Md.

18. Funeral director: Harry H. Nitzke

Address: 4101 Edmondson Ave.

19. May 14, 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/13 1947 at 1150A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/7 1947 to 5/12 1947 and that I last saw h.e.r. alive on 5/12 1947

	DURATION
Immediate cause of death: Meningitis,	4 days
acute, Type unknown, but believed	"
Due to: to be T.B. There is no doubt	"
that the pt. had a meningitis	"
Due to:	.....
.....	.....
Other conditions: Laboratory tests were done at St Agnes Hospital laboratory. To date cultures have grown no organisms. [6/25/47 ahc]	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. P. Williamson M.D. M. D. or other

Address: 3325 Frederick Ave Balto (9) Md. Date signed: 5/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03760

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years, 2 months, 15 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 12 years, 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 West Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lacey Kenly (Quinn)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	18	hrs. min.

9. Birthplace: Ridgefield, New Jersey (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Post Office

FATHER 12. Name: Edward Quinn

FATHER 13. Birthplace: New York

MOTHER 14. Maiden name: Elizabeth Lee Kenly

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24, 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Greenmount

Location: Baltimore, Md.

18. Funeral director: John O. Mitchell & Sons, Inc.

Address: 1900 Eutaw Place, Balto.-17-Md.

19. 5/23 19 47 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 47 at 8:30 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 19 35 to May 22 19 47 and that I last saw h... im... alive on May 22 19 47

Immediate cause of death	DURATION
Cardiac decompensation	4 days
Due to: Chronic C-V-R- disease	Indefini
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5-23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 037638

P

1. PLACE OF DEATH: Balto.
County: Long Grun
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Long Grun (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clara C. Rigley

3.(b) Social Security Number: 219-01-6997

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Wm. Rigley
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Apr. 14th 1871

8. AGE: Years: 76 Months: 0 Days: 30 If less than one day: hrs. min.

9. Birthplace: Frd. Co. Md. (Town, county, and state)
10. Usual occupation: Seamstress
11. Industry or business:
MOTHER FATHER
12. Name: James F. Mullen
13. Birthplace: Md.
MOTHER
14. Maiden name: Martha Howard
15. Birthplace: Md.
16. Informant: Mrs. James Bull
Address: Long Grun, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/7/47 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Balto. Md.
18. Funeral director: E. J. Fanning & Son
Address: 1938 E. Lafayette Ave.
19. 5-6-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947, at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1947 to May 4 1947 and that I last saw h.e alive on May 4 1947

Immediate cause of death (a) Congestive Heart Failure — Duration: 2 Mos.
Due to: Coronary Occlusion — 8 Mos.
Due to: Thrombophlebitis — 10 Mos.
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D. M. D. or other
Address: York, Md. Date signed: 5/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13(a)

CERTIFICATE OF DEATH

03762

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 3 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 11 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: RICHARD ROBERTSON

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: Louise Connick

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): March 26, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	6	...hrs. ...min.

9. Birthplace: Brandywine, Maryland (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: farm

FATHER — 12. Name: William Bruce Robertson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Maria Rebecca Robinson

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3-47 (month) (day) (year)

Cemetery or crematory: St. John's

Location: Broad Creek, Md.

18. Funeral director: Pitzer Bros.

Address: Upper Marlboro, Md.

19. 5-3 1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1947 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1946 to May 2 1947 and that I last saw him alive on May 2 1947

Immediate cause of death	DURATION
subdural hematoma, right, (spontaneous)	2-4 hours
Early bilateral aspiration pneumonia	
Due to: with oedema	4 "
Chronic arteriosclerotic hypertensive	
Due to: C-V-R diease	Indefinite
Arteriosclerotic coroanry diease	"
Other conditions: Pericarditis with calcified	
adhesions; Sclerotic aortitis	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

Address: Catonsville 28, Md. M. D. or other

Date signed: 5/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 P

03763

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Opitz Convalencent Home

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 620 York Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: AMELIA THERESA RUDIGIER

3. (b) Social Security Number: ///////

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: ////

6 (c) If alive, give age: ////// years

7. Birth date of deceased (mo., day, yr.): November 1, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	10	____ hrs. ____ min.

9. Birthplace: Towson, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Julius Rudigier
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary A. Debaugh
15. Birthplace: Penna.

16. Informant: E. A. Rudigier
Address: Ambassador Apts., Balto., Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Marie

Location: Towson, Md.

18. Funeral director: John Burns' Sons
Address: Towson, Md.

19. May 12 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 19 47, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45, to May 11 19 47, and that I last saw h[illegible] alive on May 10 19 47

Immediate cause of death	DURATION
(a) Acute Cardiac Failure	1 Day
Due to (b) Cerebral Arterio Sclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 5-12

M

I

VS A 15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03764 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6112 Edmondson ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6112 Edmondson Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Helena Cole Salmon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: late Joseph A

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 20, 1862

8. AGE: Years	Months	Days	If less than one day
84	8	15	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Edward F Hayes

13. Birthplace: Md

MOTHER 14. Maiden name: Stayley

15. Birthplace: Md

16. Informant: Miss Helena Dorthea Salmon

Address: 6112 Edmondson Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1947 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Greenmount av - Baltimore

18. Funeral director: Harry F Weyler

Address: 4101 Edmondson Ave

19. 5/6 1947 (Date rec'd by registrar) F W Hedrick JM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 47, at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 1939, to May 5 1947

and that I last saw h[illegible] alive on May 4 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	6 hrs
Due to: Chr. Hypertensive Cardio-Vascular Disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. M. D. or other

Address: Catonsville-28, Md Date signed: 5-6-47

2411 N. Chas.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 03765 44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Holly Neck Rd. V
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Balto. - R - Md Burney
(If outside city or town limits, write RURAL and give nearest town)
Street No. Holly Neck Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Theadore L. Schenning

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Martha Schenning
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace: Philadelphia Road Balto. County (Town, county, and state)
10. Usual occupation: Labor on Farm
11. Industry or business

FATHER
12. Name: Henry Schenning
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Rueck
15. Birthplace: Germany

16. Informant: Henry Schenning
Address: Box 363 Holly Neck Road Route 3 Balto 21
17. Burial, cremation, or removal. Which?: Burial Date thereof: 5 - 14 - 47 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore Md.
18. Funeral director: John M. Weber
Address: 401 S. Chester Street
19. May 12 19 47 (Date rec'd by registrar) A. W. Hetrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947, at 6:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11th 1947, to May 12th 1947, and that I last saw him alive on May 12th 1947.

Immediate cause of death	DURATION
Coronary Thrombosis	1 Day.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James J. White, M.D.
M. D. or other
Address: 2601 Easton Ave. Balto. 24, Md. Date signed: 5/13/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

93d 03766

8

1. PLACE OF DEATH

County Baltimore Registration Dist. No.

Village or City Catonsville No. Farmer + Maiden Choice St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary A. Scherer If U. S. Veteran, specify WAR

(a) Residence: No. 3701 Sequoia Ave St., Ward

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Scherer

6. DATE OF BIRTH (month, day, and year) 5/19/1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77		5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Nothing

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Ireland (State or country)

FATHER

13. NAME John Naegle

14. BIRTHPLACE (city or town) Ireland (State or country)

MOTHER

15. MAIDEN NAME Sarah Dowling

16. BIRTHPLACE (city or town) Ireland (State or country)

17. INFORMANT Mrs. L. J. Ogle

(Address) 3701 Sequoia

18. BURIAL, CREMATION, OR REMOVAL

Place London Park Date 5/27/47

19. UNDERTAKER John J. Tobey + Sons

(Address) 1318 Light St.

20. FILED May 26, 1947 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 24 1947

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19...; death is said to have occurred on the date stated above, at 10-30a m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Apoplexy	
Cardio Vascular disease	
sudden death	

Other Contributory Causes of Importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of Injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Geo. J. Kieffer Klapp Med. Exa. M.D.

(Address) 1010 Leader Bldg. Balto.

5-24-47

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03767 Reg. Dist. No. 3d

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years, 5 months, 22 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 48 years, 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 E. Lombard street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Katharine Sendelbach

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years	Months	Days	If less than one day
79 ?	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: ?

FATHER — 12. Name: John Sendelbach

13. Birthplace: Germany

MOTHER — 14. Maiden name: Katherine Muller

15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/47 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Edmondson avenue

18. Funeral director: Chas. J. Evans & Son Inc

Address: 118 W. Mt. Royal Ave.

19. May 29 1947 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7 1898, to May 29 1947 and that I last saw her alive on May 29 1947

Immediate cause of death	DURATION
Broncho pneumonia	2 weeks
Due to: Chronic cardiovascular-renal disease	indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Catonsville-28, Md. Date signed: 5-29-47

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03768

CERTIFICATE OF DEATH

Reg. Dist. No. 4

8207 Dundalk Ave

1. PLACE OF DEATH:
County Dundalk Md
City or town Balto Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mos
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W Virginia County
City or town Beckley
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mabscott St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elsie I Shaffer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Luther
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4 - 1881

8. AGE: Years	Months	Days	If less than one day
65	8	11	hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Robert Spears
13. Birthplace West Virginia

MOTHER 14. Maiden name —
15. Birthplace West Virginia

16. Informant Mrs Robert Williams
Address 8207 Dundalk ave

17. Removal Date thereof May 18-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Tabor
Location Beckley W Va

18. Funeral director Jos L Herr & Son
Address 3001 Kentucky ave

19. May 16 19 47 A W. Hedrick
(registrar) Registrar

JS

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 2.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1947 to May 15 1947 and that I last saw h alive on May 15 1947

Immediate cause of death	DURATION
Myocardial Infarction - Acute	11 days
Due to Coronary Occlusion	11 days
Due to A-S-C-V. Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Davis M.D.
M. D. or other
Address Dundalk Md Date signed 5/15/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 03769 (4)

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2908 Grantley Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME
DAVID SHEETS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-21-1888

8. AGE: Years	Months	Days	If less than one day
58	7	19	hrs. min.

9. Birthplace: Martinsburg, W. Va.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business
FATHER 12. Name: Charles William Sheets
13. Birthplace: Martinsburg, W. Va.
MOTHER 14. Maiden name: Lucinda Shubridge
15. Birthplace: Martinsburg, W. Va.
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-13-47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland
18. Funeral director: Loring Byers
Address: 5005 Park Heights Ave.
19. 5-12 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 19 47 at 7:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 19 47, to May 10 19 47 and that I last saw him alive on May 10 19 47

Immediate cause of death	DURATION
CARCINOMA OF THE STOMACH	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: McKnight M. D.
M. D. or other
Address: VAH, Fort Howard, Md. Date signed: 5-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-d)

CERTIFICATE OF DEATH

03770

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Providence (Towson Rt. #6)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Providence Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Providence (Towson Rt. # 6)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Providence Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ////////

3.(a) FULL NAME: HELENA AUGUSTA SHOCK

3.(b) Social Security Number: ////////

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Edward Shock

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): September 27, 1890

8. AGE: Years	Months	Days	If less than one day
56	7	28	....hrs. ....min.

9. Birthplace: Arlington, Balto. Co., Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: Peter J. Brooks

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: ? Kluth

MOTHER — 15. Birthplace: Germany

16. Informant: Charles E. Shock

Address: Providence, Balto. Co., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1947 (month) (day) (year)

Cemetery or crematory: Sater's Baptist Cemetery

Location: Brooklandville, Balto. Co., Maryland

18. Funeral director: John Burns Sons

Address: Towson, Maryland

19. May 26 1947 (Date rec'd by registrar) A. W. Hesnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1947, at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to May 24th 1947 and that I last saw h.. alive on May 23rd 1947

	DURATION
Immediate cause of death: Acute Coronary Collapse (Occlusion) Sudden	
Due to: Enlarged Heart - Arterio Sclerosis	
Due to: Hypertension (General Arterio Sclerosis)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Daniel of St. Thos. Jenifer M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03771 P

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Govans

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 435 Schwartz Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lavinia Skinner

3.(b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Mills F.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1877

8. AGE: Years: 70 Months: - Days: 8 If less than one day: ..... hrs. ..... min.

9. Birthplace: Edenton, N. C.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Mr. William L. Skinner

Address: 435 Schwartz Ave.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) May 22, 1947

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Md.

18. Funeral director: Mrs. Lew. A. Holland

Address: 1631 Druid Hill Ave.

19. (Date rec'd by registrar) 5-20 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1947, at 1:30 a. m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 9th 1944, to May 18th 1947, and that I last saw him alive on May 17th 1947

Immediate cause of death	DURATION
Coronary Occlusion	May 18th 47
Due to Arteriosclerosis	8 yrs
Due to Senility	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. S. Oberlander M. D. or other

Address: 6710 York Rd. Date signed: May 20, 1947

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

03772 32

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: BALTIMORE

City or town: GARRISON.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Reisterstown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MARY MARGARET SLADE

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Wesley Lee Slade

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Sept 8-1901

8. AGE: Years	Months	Days	If less than one day
45	8	7	...hrs. ...min.

9. Birthplace: Baltimore md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: James Henry Snyder

FATHER — 13. Birthplace: Baltimore. md

MOTHER — 14. Maiden name: Mary Brady

MOTHER — 15. Birthplace: Ireland

16. Informant: Wesley L. Slade

Address: Reisterstown Rd. Garrison md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: may 17-47 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Maryland

18. Funeral director: Frank H. Newell

Address: Pikesville. Md.

19. 5-16-1947 (Date rec'd by registrar) Dr. E. E. Nichols md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1947, at 9 15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 19... to May 15 1947

and that I last saw h... alive on May 14, 1947

Immediate cause of death	DURATION
Carcinoma of stomach	
Due to	
Due to cachexia & metastasis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: James L. Gaffell M. D. or other

Address: Reisterstown Md. Date signed: 5/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 3d 03773

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred: Spring Grove St. Hosp.
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Pr. Geo.
State: Md. County: Washington
City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)
Street No. 6409 63rd Place (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: SMITH Arthur Lee sr

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Jane Williams
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years: 78 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: ✓
FATHER 13. Birthplace: ✓
MOTHER 14. Maiden name: ✓
MOTHER 15. Birthplace: ✓
16. Informant: Hospital records
Address:
17. Burial, cremation, or removal. Which?: Removal Date thereof: May 15, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Ft. Meade Md
18. Funeral director: J. Gaschis Sons
Address: Ft. Meade, Md.
19. (Date rec'd by registrar) 7-15 1947 Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1947 at 6 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1947 to May 14 1947 and that I last saw him alive on May 14 1947

	DURATION
Immediate cause of death: Cardiac failure	6 hrs
Due to: Bronchio pneumonia	48 hrs
Due to: Chronic myocarditis	unknown
Other conditions: General advanced arteriosclerosis; cerebral hemorrhage (Include pregnancy within 3 months of death)	6 yrs

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dudley Funk M.D. M. D. or other
Address: Spring Grove St. Hosp. Date signed: May 14, 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

03774 1
33

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs., 4 mos. 17 days

Hospital, institution, or street address where death occurred:
Rosewood State Training School

How long in hospital or institution? 41 yrs 4 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME
Abraham C. Stevens

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-30-76

8. AGE: Years	Months	Days	If less than one day
71	1	7	..... hrs. ..... min.

9. Birthplace (Hampden) Baltimore City
(Town, county, and state)

10. Usual occupation Inmate

11. Industry or business

FATHER
12. Name Abraham C. Stevens
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden name Emma Jane Cullum
15. Birthplace Baltimore, Md.

18. Informant Rosewood State School Records
Address Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10-1947 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18. Funeral director Burgee Funeral Home

Address 3631 Falls Road, Baltimore

19. 5/9 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 47, at 9.50p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 47, to May 7 19 47 and that I last saw him alive on May 7 19 47

Immediate cause of death	DURATION
Myocardial Insufficiency	12 yrs
Due to with complicating pulmonary edema	2 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE /s/ Harry L. Butler M. D. or other

Address Owings Mills, Md. Date signed 5/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-d)

CERTIFICATE OF DEATH

03775

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Rosedale
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8051 Old Phila Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Michael Aloysius Stoecker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Anna M. Stoecker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1875

8. AGE:	Years	Months	Days	If less than one day
	72	1	28	..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: George Stoecker
13. Birthplace: Germany
MOTHER 14. Maiden name: Marie---
15. Birthplace: Germany
16. Informant: Mrs. Anna M. Stoecker
Address: 8051 Old Phila Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30 1947 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: Balto. Md.
18. Funeral director: Philip Stewig Sons
Address: 2024 Orleans St.
19. May 28 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1947, at 5A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1947, to May 27 1947
and that I last saw h alive on May 27 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Arteriosclerotic Cardiac Vascular Disease	6 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo M Baumgardner M. D. or other
Address: Balto 5 Md Date signed 5-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

03776

P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: 496 F. St. Baltimore -
City or town: Sparrows Point-19.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months.
Hospital, institution, or street address where death occurred:
406 F. St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Talbot.
City or town: Oxford.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) W
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Ella Sullivan.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow.

6.(b) Name of husband or wife: Lake Sullivan.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 8. 1870.

8. AGE:

Years	Months	Days	If less than one day
77	3	5	..... hrs. ..... min.

9. Birthplace: Poplar Is. Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home

FATHER
12. Name: Charles Cochran.
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth.
15. Birthplace: Md.

16. Informant: Nellie Harrison.
Address: 424 F. St. Sp. Pt.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/47 (month) (day) (year)
Cemetery or crematory: Ford
Location: Oxford Md
18. Funeral director: Wilson Ford Jr.
Address: 121 E. Ford St.

19. May 14 1947 (Date rec'd by registrar) G. W. Hewett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May. 13 19 47; at 4:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 47, to May 13 47.
and that I last saw h W alive on May. 13. 1947.

Immediate cause of death	DURATION
Hypostatic Lobar Pneumonia	2 days.
Due to: associated with apoplexy	6 days.
Due to: assoc with adeno carcinoma	
Other conditions: of right ovary	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Louis D. Tolli M.D.
M. D. or other
Address: Sparrows Point, Md. Date signed 5/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03777

P

CERTIFICATE OF DEATH

Reg. Diat. No. X 2

1. PLACE OF DEATH:

County Balto.

City or town Relay
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
5002 D St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Relay
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5002 D Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY SVEC

3.(b) Social Security Number NO

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife Joseph Svec

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 5, 1869

8. AGE: Years	Months	Days	If less than one day
78	0	15	....hrs. ....min.

9. Birthplace New York,
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name V. Jeravek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden name Mary M. Kadez
15. Birthplace Unknown

16. Informant Miss Ruth M. Svec

Address 5002 D St., Relay, Md.

17. Burial Date thereof 5/23/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 5/22 19 47 Aw Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 47 at 7 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 09, to May 20 19 47 and that I last saw h... alive on May 20 19 47

Immediate cause of death	DURATION
Left ventricular Failure	1 hour
Due to Chronic Hyp. Cardiac	2 yrs
Due to Arterio Sclerosis	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederic V. Bentley M. D. or other

Address 723 Medical Arts Bldg Balto Date signed 5-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03778

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 57

1. PLACE OF DEATH:

County Balto

City or town Sparks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred: —

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Sparks

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Horace A. Talbert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Rachel Ann Naylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1868

8. AGE: Years 78 | Months 5 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Sparks Balto Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business County Roads

FATHER
12. Name Scott Talbert
13. Birthplace Balto Co Md.

MOTHER
14. Maiden name Amy Bosley
15. Birthplace Balto Co Md.

16. Informant Mel Talbert

Address Sparks

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-47 (month) (day) (year)

Cemetery or crematory Black Rock

Location Butler, Balto Co., Md.

18. Funeral director Landon M. Brooks

Address Sparks, Md.

19. May 15, 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 11 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1946, to May 15 1947 and that I last saw h.im alive on May 14 1947.

	DURATION
Immediate cause of death Coronary Thrombosis	Sudden
Due to Myocarditis	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or other

Address Corkeysville Md. Date signed 5/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

03779

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Cole's Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 218 Bloomsbury Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sallie Eleanor Talbott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife E. W. Talbott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 11, 1876

8. AGE: Years	Months	Days	If less than one day
71	2	3	..... hrs. ..... min.

9. Birthplace Ellicott City Maryland.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Joseph H. Dishian

13. Birthplace Md.

MOTHER 14. Maiden name Sallie Hunt

15. Birthplace Maryland.

16. Informant Eleanor Talbott

Address 218 Bloomsbury Ave.

17. Burial Date thereof 5-16-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Johns

Location Ellicott City Md.

18. Funeral director J.C. Negus & Son

Address Ellicott City Md

19. 5-15 1947 Harry D. Miller Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 6 35/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1947, to May 14 1947 and that I last saw h.. alive on 5-14 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Vascular Disease	5 years.
Due to	
Due to	
Other conditions Hypertension	5 yr.

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Bungtop M.D. M.D., or other

Address Ellicott City Md Date signed 5-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Birth + Death

03780

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

1600

Reg. Dist. No. 35

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Baltimore
   City or town Rural, Parkton
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   Length of mother's stay in County Life
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County Baltimore
   City or town Rural, Parkton
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. On Susquehanna Trail, near Kauffman Road
   (If RURAL give LOCATION)

3. Name of child Carl Eugene Thomas
4. Date of birth 5-1 1947 Hour 1:10 A. M.
5. Sex male | 6. Twin or triplet no
7. No. of weeks pregnancy 36

FATHER OF CHILD

8. Full name Harry Nicholas Thomas
9. Color white 10. Age at time of this birth 46 yrs.
11. Usual occupation Farming

MOTHER OF CHILD

12. Full maiden name Dorothy Irene Wirtz
13. Color white 14. Age at time of this birth 39 yrs.
15. Usual occupation housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? no During labor? ~~yes~~
18. Pregnancy, complications of BP 200/130
19. Labor: (a) Complications of Precipitate delivery (b) Induced? no
20. (a) Was there an operation for delivery? no (Yes or No)
    (b) State all operations, if any none
    (c) Did child die before operation? no
    During operation? no

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes 1. Cord around neck 2. Head + neck caught in
    (b) Maternal causes outlet for 30 minutes before my arrival.

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature Louis Schatanoff M.D.
    (Specify if M. D., midwife, or other)
    Address New Freedom, York Co., Pa.

23. (a) ..... (b) Date thereof .....
    (Burial, cremation or removal) (month) (day) (year)
    (c) Cemetery or crematory .....
24. (a) Funeral director ?
    (b) Address .....

25. (a) May 3, 1947 (b) Mrs Howard S. Maxfield
    (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    ..... Health Officer, per .....

* See Instruction C on stub.

Child lived 30 minutes

Infant buried in V. S. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03781 43

Reg. Diat. No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Balto.

City or town: Mt Hope.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

P.O Box 106

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Mt Hope

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Roosevelt Ave & St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rhoda Bird Travers.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col.	Widowed

6.(b) Name of husband or wife: Emmanuel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace: Cannon, Ga. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: ?

13. Birthplace: ?

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: James. Hellman

Address: 7133 Woodland Ave, Phila., Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem.

Location: A. A. County, Md.

18. Funeral director: Joseph B. Locke. Jr

Address: 1304 N. Central Ave

19. 5-14-47 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Clarence M.D. M.D. or other

Address: Dundalk, Md. Date signed: 5/11/47

Evidence for change of age shown on?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03782

FILE No. G 110 MAY 12 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Brighton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Brighton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6702 Brighton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Essie Amelia Uhler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry A. Uhler
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): December 14, 1874

8. AGE: Years	Months	Days	If less than one day
~~75~~ 72	4	~~16~~ 19	....hrs. ....min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: George M. Boteler
13. Birthplace: Baltimore Md,

MOTHER
14. Maiden name: Amelia Osler
15. Birthplace: Baltimore Md.

16. Informant: Harry A. Uhler
Address: 6702 Brighton Ave. Brighton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18. Funeral director: Frank H. Newell
Address: Pekesville, Md.

19. May 3-47 (Date rec'd by registrar) E E Nuckals Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3. 19 47, at 1.30a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47, to May 3 19 47
and that I last saw h.. alive on April 25th 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 ds
Due to Chronic Hypertension	
& Arterio Sclerosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. B. Ewald M. D. or other
Address: 7201 York Rd Date signed 5-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

03783

CERTIFICATE OF DEATH

Reg. Dist. No. 44

M

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Balto - Orens Rd.

County

City or town Middle River Balto 21 - (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Unknown County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Unknown

3. (b) Social Security Number

4. Sex M

5. Color or race Bl.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years ? Months Days If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

Unknown

16. Informant

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof 6-19-47 (month) (day) (year)

Cemetery or crematory Texas Alms Home

Location Texas Md

18. Funeral director John J. Connelly

Address 418 Eastern Blvd

19. 6-19-1947 (Date rec'd by registrar) John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 3:09 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h ... alive on ... 19 ...

Immediate cause of death	DURATION
Multiple fractures of skull, legs etc.	
Due to Struck by R.R. train	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-27-47

Where did injury occur? Middle River Balto Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R. tracks

Means of injury Struck by train Injured at work? No

23. SIGNATURE M. Browarz M.D. Dep. Med. Exam. Balto. Co. M.D. or other

Address Dundalk 22 Date signed 6/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03784 4X
Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or Institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1310 Milton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JOHN J. URNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara Marie
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 4-27-96

8. AGE: Years	Months	Days	If less than one day
51	0	10	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: State Inspector
11. Industry or business:
FATHER 12. Name: Joseph Urner
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Mary Sleigh
15. Birthplace: Maryland
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof May-10-47 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Road
18. Funeral director: John C. Miller Inc.
Address: 2435 E. Oliver St
19. 5-9 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 19 47 at 4:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1947, to May 7, 1947 and that I last saw him alive on May 7, 1947

Immediate cause of death	DURATION
Uremia 132-2	10 Days
Due to: Disease of the heart. Cause: Hypertension & Arteriosclerosis	plus 5 Yrs.
Struct Les: Cardiac enlargement & Myocardial damage, Manif: Myocardial insufficiency	plus
Due to: Nephrosclerosis	2 Weeks plus.
Other conditions: Residuals of old left hemiplegia	31 months.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIRECTOR
Address: V.A.H. FORT HOWARD, MD. Date signed: 5-7-47

M. D. or Coroner

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

BIRTH + DEATH 03785

MARYLAND STATE DEPARTMENT OF HEALTH 159

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 44

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Baltimore
   City or town: Sparrows Point
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: 2903 Sparrows Point Road
   Length of mother's stay in County: 5 yrs.
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State:
   County:
   City or town: Same as #1
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.:
   (If RURAL give LOCATION)

3. Name of child: Baby Girl Weinreich
4. Date of birth: May 23 1947 Hour: 11:15 A.M.
5. Sex: Female 6. Twin or triplet: —
7. No. of weeks pregnancy: 23 weeks

FATHER OF CHILD

8. Full name: Charles William Weinreich
9. Color: W 10. Age at time of this birth: 25 yrs.
11. Usual occupation: Electrical worker

MOTHER OF CHILD

12. Full maiden name: Maxine Adair Hulting
13. Color: W 14. Age at time of this birth: 23 yrs.
15. Usual occupation: Housf.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of: None apparent
19. Labor: (a) Complications of: None
(b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
(b) State all operations, if any: —
(c) Did child die before operation? —
During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes: Prematurity
(b) Maternal causes: Unknown

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
Signature: Robert E. Farber, M.D.
(Specify if M. D., midwife, or other)
Address: 914 D St., Sp. Pt., Md.

23. (a) Burial (b) Date thereof 5/23/47
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory: 2903 Sp. Pt. Rd
24. (a) Funeral director: Charles Weinreich (father)
(b) Address: 2903 Sp. Pt. Rd.

25. (a) May 24 47 (b) Damon L. Harbes
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

* See Instruction C on stub.

V. S. A10

M

I

Child lived 15 mins.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 03786 41

Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

I

1. PLACE OF DEATH
County Balto
City or town Dundalk - rr
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Md County Balto
City or town Dundalk - rr
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jody Wells.

3.(b) Social Security Number

4. Sex M. | 5. Color or race Bl | 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife May L. Wells

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1897

8. AGE: Years 50 | Months | Days | If less than one day ..hrs. ..min.

9. Birthplace Isle White County Va
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Charles Wells

13. Birthplace Va.

MOTHER 14. Maiden name Lee Jones

15. Birthplace Va.

16. Informant Willie Wells

Address 306 Locust Ave Dundalk

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 28/47 (month) (day) (year)

Cemetery or crematory

Location Smithfield Va.

18. Funeral director Mrs E.H. Edwards Dept

Address 1129 N. Caroline St.

19. May 26 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..19.. to ..19..

and that I last saw h.. alive on ..19..

Immediate cause of death Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M B Davis MD

Dept Med Examiner Baltimore

Address Date signed 5/26

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-C)

CERTIFICATE OF DEATH

03787

Reg. Diat. No. 42

1. PLACE OF DEATH:
County: BALTIMORE
City or town: LANSDOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County:
City or town: LANSDOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 323 - 1st AVE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: TIMOTHY D WILBIE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 16-1946

8. AGE: Years | Months: 9 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: BALTO MD - city
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: ROBT. D WILBIE
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: FLORENCE SCHAFFNER
15. Birthplace: BALTO MD

16. Informant: FLORENCE WILBIE
Address: 323 - 1st AVE LANSDOWN.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: MAY-29-47 (month) (day) (year)
Cemetery or crematory: PARKWOOD CEM.
Location: PARKVILLE MD

18. Funeral director: Bernard C Hasler
Address: 131 E West St

19. May 29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY - 28 1947, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 28 1947 and that I last saw him alive on May 28 1947

Immediate cause of death	DURATION
Meningococcemia	1 Wk.
Due to: Congenital	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul A. Hill M. D. or other
Address: [illegible] Date signed: 5/31/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53a

Registered No. C 51436

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6807 York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 03788
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6807 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN S. WILLIAMSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Rebecca Williams nee Houk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1861

8. AGE: Years	Months	Days	If less than one day
85	9	7	hr. min.

9. Birthplace Ellicott City, Md.
(Town, county, and state)
10. Usual Occupation Grocery Business (Retired)
11. Industry or business

FATHER
12. Name Riley Williamson
13. Birthplace England

MOTHER
14. Maiden Name - Pierce
15. Birthplace Maryland

16 (a) Informant Mr. F. P. Williamson son
(b) Address 6807 York Rd.

17 (a) Burial (b) Date thereof 5/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 7 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1947, at 5:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to May 6 1947, and that I last saw him alive on May 6 1947.

Immediate cause of death	Duration
a CVA side Hemiplegia	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence C. Tosh M.D.
M. D.
Address 6805 York Rd Date signed 5/6/47

VS 150

Dr. White
5214 Harford Rd

Maryland State Department of Health
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 38P
0378

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland Co. Towson
(b) Street address Regester Ave & Loch Hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ~~City or town~~ Co. Baltimore - Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Regester Ave. & Loch Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENORE L. WILLING

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John T. Willing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1878

8. AGE: Years	Months	Days	If less than one day
68	11	9	hr. min.

9. Birthplace Fox Boro., Mass (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Rufus H. Baker
13. Birthplace China, Maine

MOTHER
14. Maiden Name Ida A. Leighton
15. Birthplace New Hampshire

16 (a) Informant Mrs. Elizabeth Willing
(b) Address Regester Ave & Loch Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 5/19/47 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th, 19 47 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 19 47 to May 17 19 47, and that I last saw her alive on May 16 19 47

Immediate cause of death	Duration
Hemorrhage Cerebral	1½ days
Due to Right side, with Hemiplegia left.	
Due to Hypertensive Arterio-sclerotic Heart Disease	11 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature James E. White
Address 5214 Harford Road Date signed 5/17/47 M D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

V S 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03790 P

182

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County: Balto.

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Slag Dump East End

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4 Township

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Beverley B. Wimbish.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 13, 1904

8. AGE:

Years	Months	Days	If less than one day
43	1	29	hrs. min.

9. Birthplace: Scottsburg, Va.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: John Randolph Wimbish

13. Birthplace: Natherlie, Va.

MOTHER

14. Maiden name: Nancy Barkdale

15. Birthplace: Sutherlin, Va,

16. Informant: Frank B. Bliley, Fun'l. Dir.

Address: Richmond, Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5/12/47 (month) (day) (year)

Cemetery or crematory

Location: Richmond, Va.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5-12 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 19 47, at 1 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 19 45, to May 12 19 45

and that I last saw h alive on 19

Immediate cause of death	DURATION
Suffocation & 2nd° Burns Chest & Legs	
Due to Burned under Fet	
Due to Slag fu Thro.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. M. Cameron M.D.

M. D. or other

Address: Dundalk, Md. Date signed: 5-14-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

03791

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Colorado Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Catherine Zimmerman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Julius E. Zimmerman
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 25, 1863.

8. AGE:

Years	Months	Days	If less than one day
83	6	30	Hrs. min.

9. Birthplace: Baltimore Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Mrs. Ida Ruley
Address: Colorado Ave. Randallstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore Co. Md.
18. Funeral director: E. Willis Lamoreau
Address: 4510 Liberty Heights Ave
19. 5/24/1947 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 1947, at 10 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1947, to May 24 1947
and that I last saw h~~er~~ alive on May 24th, 1947

Immediate cause of death	DURATION
Gangrene of feet	
Due to Arteriosclerosis &	
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other
Address: Randallstown Date signed: 5/24/47